# Ambridge Rose Manor Limited

## Current Status: 10 March 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

Ambridge Rose Manor is certified to provide hospital and rest home level of care for up to 104 residents. There were 101 residents on day of audit, including 92 at a hospital-level of care and nine at rest home level of care. The service is owned and operated by a husband and wife. The husband is the chief executive officer/owner and his spouse is the owner/manager of the facility. The management team includes a general manager, quality manager, registered nurse supervisor and clinical manager. There are 112 staff employed by the service.

There are improvements required relating to advance directives, medication management and restraint assessments.

## Audit Summary as at 10 March 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 |
|  | 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 10 March 2014

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

### Organisational Management as at 10 March 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 10 March 2014

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

### Safe and Appropriate Environment as at 10 March 2014

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

### Restraint Minimisation and Safe Practice as at 10 March 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

### Infection Prevention and Control as at 10 March 2014

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| 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 10 March 2014

### Consumer Rights

Staff understand the rights of the residents. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is displayed throughout the facility, including in each of the residents’ rooms.

The residents’ cultural, spiritual and individual values and beliefs are assessed on admission. Interviews with residents and family confirm their values and beliefs are upheld by the service.

Informed consent policy and processes are implemented by the service to meet contractual requirements. Staff demonstrate awareness of ensuring residents are informed and have choices related to the care they receive. There is one required improvement to ensure ‘not for resuscitation’ advance directives are completed correctly.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

### Organisational Management

The governing body ensures services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents.

Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.

Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training programmes are in place with mandatory training being monitored.

Staffing levels exceed those of a facility with rest home and hospital level residents. The facility is staffed for a facility that is filled with hospital-level residents although during the audit there were nine rest home level residents living at the facility.

### Continuum of Service Delivery

Ambridge Rose Manor has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit). Care plans have has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services and residents/family/whanau interviewed confirm that care provided is consistent with meeting the resident’s needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. The GP reviews residents at least three monthly or earlier as required.

Planned activities are appropriate to the rest home and hospital residents. Activities occur in all areas of the facility. Community links are maintained and entertainment and outings are scheduled. Activity plans are individualised and were evidenced to be reviewed six monthly. Residents and family interviewed confirm satisfaction with the activities programme.

There are documented medication policies and procedures. All medication charts sampled have photo identification and allergy status documented. There are improvements required around aspects of medication documentation.

Food service is provided on site and kitchen staff have completed food safety training. The dietitian has reviewed the menu and visits the service monthly. Residents' individual dietary needs are identified, documented and reviewed on a regular basis.

### Safe and Appropriate Environment

The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemicals are stored safely throughout the facility. There is a current building warrant of fitness that expires 25 March 2014. There is a reactive and planned maintenance programme. The internal and external building is well maintained. All electrical equipment has been tested. Clinical equipment has been calibrated. All bedrooms are single with hand basins. The majority of bedrooms have en-suites and there are sufficient communal shower and toilet facilities available in each of the six wings. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas, courtyard and gardens with suitable seating and shade sails. Residents are being provided with safe and hygienic cleaning and laundry services.

### Restraint Minimisation and Safe Practice

Restraint is regarded as the last resort. Any restraint/enabler use is recorded in an auditable format. Restraint training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire.

A system of evaluation and review of any restraints/enablers used by residents takes place following the initial month of using a restraint and three-monthly thereafter.

Annual reviews of the restraint minimisation programme include the review of policies and procedures and review of restraint minimisation education for staff.

There is an improvement required around restraint assessments.

### Infection Prevention and Control

There are comprehensive infection control policies that meet current best practice. The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has two infection control coordinators with defined roles and reporting responsibilities. Reports and surveillance data are discussed at staff meetings. Trends, corrective actions and quality improvements are ongoing. There is evidence of the ongoing analysis of surveillance data and improved reduction of infections. All staff received infection control education on orientation and attend six monthly education. Hand hygiene competencies are completed.

# 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**

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| --- | --- |
| **Legal entity name:** | Ambridge Rose Manor Limited |
| **Certificate name:** | Ambridge Rose Manor Limited |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Ambridge Rose Manor | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 10 March 2014 | **End date:** | 11 March 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 101 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 19 | Total audit hours | 51 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 12 | Number of managers interviewed | 6 |
| Number of residents’ records reviewed | 11 | Number of staff records reviewed | 11 | Total number of managers (headcount) | 6 |
| Number of medication records reviewed | 22 | Total number of staff (headcount) | 112 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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| --- | --- | --- |
| 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 Tuesday, 15 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Ambridge Rose Manor is certified to provide hospital and rest home level of care for up to 104 residents. There were 101 residents on day of audit, including 92 at a hospital-level of care and nine at rest home level of care. The service is owned and operated by a husband and wife. The husband is the chief executive officer/owner and his spouse is the owner/manager of the facility. The management team includes a general manager, quality manager, registered nurse supervisor and clinical manager. There are 112 staff employed by the service. There are improvements required relating to advance directives, medication management and restraint assessments. |

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| **Outcome 1.1: Consumer Rights** |
| Staff understand the rights of the residents. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is displayed throughout the facility, including in each of the residents’ rooms.  The residents’ cultural, spiritual and individual values and beliefs are assessed on admission. Interviews with residents and family confirm their values and beliefs are upheld by the service. Informed consent policy and processes are implemented by the service to meet contractual requirements. Staff demonstrate awareness of ensuring residents are informed and have choices related to the care they receive. There is one required improvement to ensure ‘not for resuscitation’ advance directives are completed correctly. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place. |

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| **Outcome 1.2: Organisational Management** |
| The governing body ensures services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents.  Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner. Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training programmes are in place with mandatory training being monitored. Staffing levels exceed those of a facility with rest home and hospital level residents. The facility is staffed for a facility that is filled with hospital-level residents although during the audit there were nine rest home level residents living at the facility. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Ambridge Rose Manor has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit). Care plans have has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services and residents/family/whanau interviewed confirm that care provided is consistent with meeting the resident’s needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. The GP reviews residents at least three monthly or earlier as required.  Planned activities are appropriate to the rest home and hospital residents. Activities occur in all areas of the facility. Community links are maintained and entertainment and outings are scheduled. Activity plans are individualised and were evidenced to be reviewed six monthly. Residents and family interviewed confirm satisfaction with the activities programme. There are documented medication policies and procedures. All medication charts sampled have photo identification and allergy status documented. There are improvements required around aspects of medication documentation.   Food service is provided on site and kitchen staff have completed food safety training. The dietitian has reviewed the menu and visits the service monthly. Residents' individual dietary needs are identified, documented and reviewed on a regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemicals are stored safely throughout the facility. There is a current building warrant of fitness that expires 25 March 2014. There is a reactive and planned maintenance programme. The internal and external building is well maintained. All electrical equipment has been tested. Clinical equipment has been calibrated. All bedrooms are single with hand basins. The majority of bedrooms have en-suites and there are sufficient communal shower and toilet facilities available in each of the six wings. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas, courtyard and gardens with suitable seating and shade sails. Residents are being provided with safe and hygienic cleaning and laundry services. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint is regarded as the last resort. Any restraint/enabler use is recorded in an auditable format. At the time of the audit, 20 residents were using a restraint and no residents were using an enabler. Restraint training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire.  A system of evaluation and review of any restraints/enablers used by residents takes place following the initial month of using a restraint and three-monthly thereafter.  Annual reviews of the restraint minimisation programme include the review of policies and procedures and review of restraint minimisation education for staff. There is an improvement required around restraint assessments. |

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| **Outcome 3: Infection Prevention and Control** |
| There are comprehensive infection control policies that meet current best practice.The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has two infection control coordinators with defined roles and reporting responsibilties. Reports and surveillance data are discussed at staff meetings. Trends, corrective actions and quality improvements are ongoing. There is evidence of the ongoing analysis of surveillance data and improved reduction of infections. All staff received infection control education on orientation and attend six monthly education. Hand hygiene completencies are completed. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 47 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 2 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | Four of 11 advanced directive forms are not completed appropriately as the resident is deemed incompetent to make this decision. | Implement the medically indicated “not for resuscitation” forms for resident deemed incompetent to make a decision. The GP and clinical manager initiated corrective action on the day of audit. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)There is no formal medication reconciliation on delivery of medications. (ii) There is transcribing of prn medications on 12 of 22 medication non-packaged signing sheets. (iii) Ten of 22 medication charts do not have indications for use of prn medications. | (i)A medication reconciliation form is developed on the day of audit to be implemented with the next delivery of medication; (ii) Transcribing of prn medications to cease. (iii) PRN medications require an indication for use on the medication chart. | 30 |
| HDS(RMSP)S.2008 | Standard 2.2.2: Assessment | Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.2.1 | In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | A comprehensive restraint assessment was previously in place in hard copy and has been discontinued. Indicators for restraint use are determined on the residents’ falls assessment. No restraint assessment is in place either in hard copy or electronically. | Ensure a restraint assessment process is implemented which covers all aspects of the criterion. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive education on The Code of Health and Disability Consumers’ Rights (the Code) during their induction to the service and through the two-yearly mandatory education programme. Interviews with seven healthcare assistants, one registered nurse, one enrolled nurse, the clinical manager, and the registered nurse supervisor confirm their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Administrative staff discuss the Code, including the complaints process, with residents and their family during their pre-admission to the service. Discussions relating to the Code are also held during the six-monthly residents' meetings (meeting minutes sighted). A recent residents’ meeting (6 March 2014) included a speaker from the Health and Disability Commissioner’s Office. Family are invited to attend the residents’ meetings. The Code is displayed in each resident room. An information folder is also contained in each resident room, and includes information relating to residents’ rights, suggestions and complaints, privacy and a complaints form. Seven residents (three rest home level and four hospital level) and seven relatives interviewed report their rights are being upheld by the service. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents’ right to privacy and dignity is recognised and respected. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the residents’ rooms. Seven healthcare assistants (HCAs) interviewed report they knock on bedroom doors prior to entering rooms, ensure doors and curtains are shut when cares are being given and do not hold personal discussions in public areas. Seven residents (three rest home level and four hospital level) and seven relatives interviewed confirm the residents’ privacy is respected. They report that they encourage the residents' independence by encouraging them to be as active as possible. The service is committed to the prevention and detection of abuse and neglect by ensuring the provision of quality care. Guidelines are provided to staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the service’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code of Health and Disability Consumers’ Rights.  There have been no reported instances of abuse or neglect at this facility. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the two-yearly mandatory education programme. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is committed to ensure that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered. They value and encourage active participation and input of family/whanau in the day-to-day care of the resident. Consultation is sought through a kaumatua from the local marae. The general manager reports the kaumatua has blessed the facility. Staff receive education on cultural awareness at orientation and through the two-yearly cultural education programme.  There were no Maori residents living at the facility during this full certification audit. Interviews with seven healthcare assistants, one registered nurse, one enrolled nurse, the clinical manager, and the registered nurse supervisor confirm specific cultural needs are identified in the residents’ care plans. This was also evidenced in the review of all 11 residents’ files that were randomly selected for audit (three rest home level and eight hospital level). Staff are aware of the importance of whanau in the delivery of care for Maori residents. Three staff identify as Maori. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline.  Long-term care plans are completed within three weeks of admission, evidenced in 11 of 11 care plans reviewed (three rest home level and eight hospital level). All eleven residents’ files reflect input from family/whanau on the residents’ care plans. Beliefs and values are discussed and incorporated into the care plan. Following the initial care-planning meeting, six monthly multi-disciplinary team meetings are scheduled. Family are invited to attend GP visits and multidisciplinary meetings. Seven of seven residents (three rest home level and four hospital level) and seven of seven family members interviewed confirm they are involved in developing a plan of care for their family member, which includes the identification of individual values and beliefs. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All staff have position descriptions to describe their working boundaries in caring for the residents, evidenced in 11 of 11 staff files reviewed. The induction programme at the commencement of employment provides staff with an understanding of what are acceptable standards of care. House rules are discussed in the induction programme with a copy of the house rules posted in a visible location in the staff room. There are no instances reported, observed or identified by the auditors whereby professional boundaries were ignored at the expense or wellbeing of the residents. Interviews with seven of seven healthcare assistants confirm their understanding of professional boundaries, including the boundaries of the healthcare assistants’ role and responsibilities. Professional boundaries are reconfirmed through education sessions, discussions at handover, staff meetings, and performance management if there is infringement with the person concerned. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Evidence-based practice is evident, promoting and encouraging good practice (evidenced in interviews with the CEO, quality manager, clinical manager and registered nurse supervisor).  Examples of good practice include policies and procedures that are linked to evidence-based practice, links with the gerontology nurse specialist from Counties Manukau District Health Board, and ongoing professional development for staff with opportunities for the registered nurses to attend external seminars. Monthly in-service education is provided for staff. Staff access external education that is focused on aged care and best practice.  The service models the principals of continuous quality improvement with a number of quality initiatives underway to improve service delivery. A general practitioner (GP) is available 24 hours a day, seven days a week and visits the facility a minimum of weekly. The GP reports that a high standard level of care is provided and the registered nursing staff demonstrate good clinical assessment skills.  Seven of seven residents (three rest home level and four hospital level) and seven of seven families interviewed expressed their satisfaction with the care delivered. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation promotes a clear and consistent approach to open disclosure. Families are informed of any untoward event. Discussions are held with residents and relatives regarding any changes in care provision.  Seven of seven residents (three rest home level and four hospital level) and seven of seven families interviewed report they kept informed. This was also evidenced in the satisfaction survey questionnaires whereby 100% of family responded that they are kept informed following an adverse event. The organisation has multilingual staff that can provide interpreter services where family are not available. Signage and sign language is also used to assist with communication. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Seven health care assistants interviewed are familiar with the Code of Health and Disability Consumers’ Rights and informed consent and described the link between the home's philosophy and choice and consent on a daily basis. Informed consent forms are evident in eleven (three rest home and eight hospital) of 11 resident files reviewed. Four of 11 advanced directives are not completed appropriately as the resident is deemed incompetent to make a decision. The service has a medically indicated “not for resuscitation form” that evidences GP discussion with family members regarding resuscitation status. Informed consent and advance directive forms are reviewed annually.  D13.1 There were 11 signed admission agreements sighted.  D3.1.d Discussions with seven family (two rest home and five hospital) identify that the service actively involves them in decisions that affect their relative’s lives |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Informed consent forms are evident on 11 (three rest home and eight hospital) of 11 resident files reviewed. Eight of 11 advanced directives are completed appropriately. The service has a medically indicated “not for resuscitation form” that evidences GP discussion with family members regarding resuscitation status. Informed consent and advance directive forms are reviewed annually. |
| **Finding:** |
| Four of 11 advanced directive forms are not completed appropriately as the resident is deemed incompetent to make this decision. |
| **Corrective Action:** |
| Implement the medically indicated “not for resuscitation” forms for resident deemed incompetent to make a decision. The GP and clinical manager initiated corrective action on the day of audit. |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information on Advocacy Services through the Health and Disability Commissioners (HDC) Office is included in the resident information that is provided to residents and their family on admission. This information is also held in each resident room.  Information on the role of advocacy services is also provided during residents’ meetings (evidenced in review of the residents’ meeting minutes). Pamphlets on advocacy services are available at reception. Seven of seven residents (three rest home level and four hospital level) and seven of seven families interviewed report they have been informed regarding advocacy services. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured at night but visitors can arrange to visit after doors are locked. Seven of seven relatives interviewed confirm they can visit at any reasonable time and are always made to feel welcome.  The service encourages the residents to maintain their relationships with their friends, and community groups. A van is available for weekly outings. Residents are encouraged to attend functions and events that are held at the facility.  This facility is predominately occupied with hospital-level residents. This does not impact on the socialisation for the nine rest home level residents, which was verified during interviews with three rest home residents, one family member with a resident at the rest home level of care, and an interview with the activities coordinator. |

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

Consumers have access to visitors of their choice.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints policy is in line with the Code of Health and Disability Services Consumers’ Rights and includes time-frames for responding to a complaint. Complaints forms are available in the reception area and in the resident information folder, which is held in each resident room. A complaints register is in place. Fourteen complaints were lodged in 2013 and two complaints in 2014 (year-to-date). The complaints folder includes the date the complaint was received; the source of the complaint; a description of the complaint; an investigation of the complaint and the date the complaint was resolved. Also documented is whether the Health and Disability Advocacy Service was used. One complaint was lodged with the Health and Disability Commissioner’s Office (HDC) and included an external peer review. The complaint relates to a resident on respite care. Recommendations made by the Commissioner’s Office have been acknowledged with evidence of discussions and actions taken in the manager’s meeting minutes. This complaint has been closed by HDC. All four complaints selected for review meet time-frames for acknowledging, investigating and responding to the complainant. Complaints are regularly discussed in meeting minutes, with in-depth discussions in the management meetings. Also documented are the actions taken to minimise further episodes. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is owned and operated by a husband and wife team. The husband is the chief executive officer/owner. He holds a Diploma in Business and a Diploma in Management. He is the current New Zealand Aged Care Association (NZACA) Counties Manukau Branch Chairman. His spouse is the owner/manager of the facility. She holds a national certificate in Mental Health Level 4 and National Certificate in Health and Aged Support Level 3. They have owned the facility for 12 years.  A team of managers (general manager, quality manager, registered nurse supervisor and clinical manager) support the owners. The service can provide care for up to 104 residents with all 104 beds certified as hospital/medical or rest home level care. There were 92 hospital-level residents and nine rest home level residents living at the facility during this full certification audit. No residents were on the medical contract. The organisation has a clear purpose, values, scope, direction and strategic goals that are regularly reviewed. Strategic planning meetings are held six-monthly. The chief executive officer is responsible for the overall management of the facility. He and his managers regularly attend aged care conferences and external professional development courses relating to the management of the facility, exceeding eight hours per year. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the chief executive officer/owner and manager/owner, the general manager is in charge of the facility. Clinical responsibility is delegated to the clinical nurse manager and registered nurse supervisor. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A quality policy statement is in place that aligns with the mission and philosophy of the service. Goals and objectives are defined under the categories of: consumer focus; provision of effective programmes; certification and contractual requirements; quality and risk management; and continuous improvement. The quality and risk management plan was last reviewed on 31 January 2014.  The risk management plan lists risks to the organisation and mitigating strategies. It is currently in the process of being entered into an electronic database that has recently been developed for the service. The quality manager leads the quality programme. The managers and staff understand the principals of continuous quality improvement.  Policies are in place for all aspects of the service. All policies are subject to reviews as required and a minimum of two-yearly. Evidence of policy reviews are documented in the footer section of each policy. Policies are readily available to staff in hard copy. Electronic versions of policies are also available. Policies are up-to-date and are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines.  A document management process controls policies and procedures. New and revised policies are discussed in applicable meetings. For example, the procedure for the application of topical creams was recently revised. The policy was updated and changes to the policy were discussed in staff meetings (meeting minutes sighted). Service delivery is monitored through incident and accident reporting, complaints management, infection control monitoring, health and safety compliance and restraint monitoring.  Data is collected monthly for infection rates, incidents and accidents, skin integrity, medication errors, restraint use and challenging behaviours. Results are provided to staff, evidenced in the staff meetings.  An internal auditing programme monitors 31 key aspects of the service. Audit results are provided to staff with evidence of discussions relating to the corrective actions that are put into place (where indicated by the internal audit results). Achievements against the quality and risk management plan are highlighted.  The service reflects a culture of continuous quality improvement with numerous quality initiatives. Examples of quality initiatives include (but not limited to): a) the implementation of electronic software programmes to enhance both clinical documentation and management systems; b) implementing initiatives to reduce the frequency of falls including regular medication reviews; c) staffing each of the six wings with the same staff to assist in meeting the residents’ individual needs; d) renovating the external garden area, and e) implementing financial incentives for the healthcare assistants who have been appointed as team leaders.  Corrective action plans are developed and documented where opportunities for improvements are identified. Corrective actions are evidenced in the internal audits where results are suboptimal. Meeting minutes reflect discussions relating to the corrective actions (sighted in the management meetings, registered nurse (RN(/enrolled nurse (EN) meetings, healthcare assistants meetings, housekeeping meetings, kitchen meetings, administrative meetings and activities meetings). All staff interviewed (seven healthcare assistants, three registered nurses including the clinical manager and registered nurse supervisor, one enrolled nurse, the activities coordinator, and food services staff) report they are kept informed of quality improvements and corrective action plans. The service has a risk management plan in place that documents risks associated with the service, along with mitigating strategies. The service has achieved their secondary ACC Workplace Safety and Management Practice certificate with plans to achieve tertiary status in 2014. A hazard register is in place that identifies hazards and includes risk management strategies, such as minimisation, isolation or elimination. Health and safety is a regular agenda item in all meetings. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The CEO/owner is aware of situations in which he would need to report and notify statutory authorities. The service is committed to providing an environment in which all staff are encouraged to recognise and report errors or mistakes and are supported through the open disclosure process.  Staff receive education at orientation on the incident and accident reporting process. Seven of seven healthcare assistants, three of three registered nurses (including the clinical manager and registered nurse supervisor) and one of one enrolled nurse interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.  Eight incident reports were randomly selected for review, which included one serious injury that necessitated a transfer to the public hospital. There is a full investigation following each incident with a registered nurse investigating all clinical events. Once a full investigation has been completed, accidents and incidents are signed off by the general manager. There is evidence of open disclosure for each recorded event (reference 1.1.9).  A monthly summary sheet of adverse events is trended and analysed for service improvements, evidenced in interviews with the general manager and clinical manager and in the review of meeting minutes. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Copies of practicing certificates were sighted for the registered nurses (nine), enrolled nurses (two), GPs (two), physiotherapist, podiatrist, and dietitian.  Eleven staff files were randomly selected for review (four registered nurses, three healthcare assistants, one quality manager, one activities coordinator, and two kitchen staff). Evidence of a signed employment contract and job description were sighted in each of the 11 staff files.  All staff undergo a comprehensive orientation programme (evidenced in all 11 staff files) that meets the educational requirements of the ARC contract. Healthcare assistants are paired with a senior caregiver for a minimum of three days or until they demonstrate competency. Annual medication competencies are completed for all staff who administer medicines to residents (registered nurses, enrolled nurses, team leaders (healthcare assistants). All 11 staff files contain evidence of annual performance appraisals.   The mandatory education programme includes education and training sessions that are held monthly and at different times to facilitate staff attendance.  Out of 72 healthcare assistants, 31 have achieved a national certificate in aged care education (14 have their basic ACE certificate, 10 have their advanced ACE certificate and seven have their dementia ACE certificate). Eighteen healthcare assistants are enrolled in the ACE programme and only 23 remain who are not currently enrolled in the ACE programme. Plans are in place to promote ACE qualification for all healthcare assistants. Mandatory two-yearly training includes 26 topics, which are tracked per staff member. Staff attendance is linked to their performance management. External education is available for the registered nurses with courses offered through Counties Manukau District Health Board. The CMDHB Gerontology Nurse Specialist provides clinical updates. The managers regularly attend aged care conferences. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A ‘Good Employer Policy’ is in place to ensure staffing levels are consistent with current legislation and reflect the needs of the residents. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. The CEO reports staffing is determined based on occupancy of hospital level residents only occupying beds.  Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.  The facility is on two levels with three wings in each level and 17 to 18 beds in each wing. An RN designated for each level during the AM and PM shifts with one RN for the entire facility during the night shift Three healthcare assistants staff each of the six wings on the AM and PM shifts. In addition, there are two floating healthcare assistants on the AM and PM shifts. The night shift is staffed with eight healthcare assistants, one in each wing and two floating where needed. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The resident files are appropriate to the service type. Residents entering the service have the relevant initial information recorded within 24 hours of entry into the service. Long-term care plans are completed within three weeks of the resident entering the service, evidenced in all eleven residents’ files. Residents’ files are documented electronically using the Leecare software system. Pertinent and applicable information is also held in hard copy in duplicate. An on-site server is used for the back-up of residents’ files. In addition, three rotating memory sticks contain back-up information that are stored off-site.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being password protected for all electronic information. Hard copy information is held in a secure cabinet or secure storage for archived files. Care plans and progress notes are typed, signed and dated and include the designation of the service provider.  Individual residents’ files demonstrate service integration. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry all potential residents have a needs assessment, completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. Seven residents (two rest home and five hospital) and seven family/whanau (two rest home and five hospital) confirm they had received all relevant information prior to or on admission. The resident/family/whanau are invited to view the facility, receive an information pack and admission agreement.  The admissions co-ordinator confirms the level of care and specific needs with the assessor. Information is then forwarded to the admitting registered nurse (RN).   D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.  D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The admission policy describes the declined entry to services process. There have been no declined entries at Ambridge Rose Manor. Reasons for declining entry would be if the provider is unable to deliver the level of care, the resident has serious psychiatric problems or the resident’s behaviour may affect the other residents. Should this occur the resident/family/whanau would be referred back to the referral agency. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures.  D16.2, 3, 4 In eleven of eleven resident files sampled (three rest home and eight hospital) the initial admission assessment and care plan are completed and signed off by a registered nurse within 24 hours. Within three weeks the long term care plan is developed in the eleven of eleven resident files sampled.  The resident assessment is carried out on admission and reviewed six monthly or earlier if resident health status changes. These are completed by the registered nurse (RN) with input from healthcare assistants (HCAs), the activities co-ordinators, family/whanau and any other relevant person. All resident details, assessments, care plans, evaluations, infections, accidents/incidents and care related information is entered into the Leecare (electronic) system. All staff have access to the system.  There is evidence of resident and/or family/whanau/EPOA involvement in the care planning process. Activity assessments and the activities care plans have been completed by the activities supervisor.   There comprehensive handovers for all RNs and HCAs at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Seven HCAs could describe a verbal handover at the start of each duty that maintains a continuity of service delivery. Entries into progress notes for rest home and hospital residents are every 24 hours and if there are any significant events.  Files reviewed identified integration of allied health including (but not limited to) general practitioner, physiotherapist, podiatrist, dietitian, speech language therapist and mental health services. The physiotherapist visits fortnightly to follow up residents under their care, and assess new referrals.    Medical assessments are completed within 48 hours of admission by the contracted GP in eleven of eleven resident files sampled. The contracted GP (interviewed) visits the service weekly to complete routine three monthly reviews and to see any residents the RNs are concerned about. The GP documents on the resident file if the resident is stable and for three monthly visits. There is a monthly medication review with the geriatrician and pharmacist. The GP liaises closely with the geriatrician and psychogeriatric services. Faxes or phone calls are received from the RNs requesting visits at any other time. The GP is available 24/7 and states all calls and requests for visits are appropriate. He is confident in the RN clinical assessments and ability to follow and carry out his instructions. The GP meets with family members during his weekly round or at the practice. The GP receives positive feedback on the service from families. A locum is provided to cover leave.  The speciality gerontology nurse (interviewed) visits by referral and also follows up all new admissions. She is available to meet with families and liaises closely with the GP and the NASC team. The gerontology nurse provides an onsite advanced assessment programme for the RNs.   Tracer methodology: Hospital resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology: Rest home resident  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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment and the first resident care plan. Relatives and residents advised on interview that assessments were completed in the privacy of their single room.  A range of assessment tools is completed on admission if applicable including (but not limited to); a) mini nutritional assessment b) falls risk assessment c) pressure area risk and skin assessment d) three to four day continence and bowel assessment on admission e) wound assessment f) restraint assessment and g) pain assessment h) behaviour assessment i) mini mental examination (as applicable). The outcomes of assessments as applicable are documented in the care plans of eleven resident files sampled. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN meets with resident and family three weeks post admission for input and feedback on activities of daily living prior to developing the long term care plan. The long term care plan kept on the Leecare system documents the name of the resident/family/whanau involved in the care planning process. Primary care plans (sighted) are displayed (signed consent obtained) in the resident rooms for quick reference for the HCAs delivering care. Care interventions and goals include (but not limited to); hygiene cares, toileting times, medical diagnosis, mobility, skin care and other relevant information for resident care and safety. Short term care plans for acute short term needs are entered on the Leecare system and are signed off as resolved. There is InterRAI training in progress for the clinical manager and RNs. The physio develops physiotherapy plans where relevant for the resident. The dietitian visits monthly and develops nutritional plans for residents eg. Percutaneous endoscopic gastrostomy (peg) feed residents that are under the care of the dietitian. Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. Allied health professional involvement in resident care is linked to the resident long term care plan.   D16.3f: Eleven of eleven resident files reviewed identified that family were involved. Relatives interviewed (two rest home and five hospital) confirmed they are involved in the care planning process.  D16.3k: Short term care plans are in use for changes in health status. Short term care plans are sighted for weight loss, incontinence, post hand surgery, disturbing behaviour, seizures, and wounds. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Ambridge Rose Manor provides services for residents requiring rest home and hospital level of care.  Individualised care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse specialist consultation. The seven HCAs interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care. Relatives interviewed state their relatives needs are being met and they are kept informed of any changes to the resident health, GP visits, accidents/incidents, infections, and hospital appointments.    Comprehensive wound assessments are completed by the RN for three peg sites, one suprapubic catheter site, one infected toe and a sacral pressure area (upstairs) and one pressure area of heel (downstairs). Wound treatment plans record the types of dressings and dressing frequency. Photographs are evident of the pressure areas. There is evidence of pressure area management documented in the care plans including four hourly turning charts (sighted), air alternating mattresses, roho cushions and pressure area bootees. The GP is notified (written into medical notes) and reviews the wounds as required. The wound nurse is available by referral.  Resident files include a three to four day urinary and bowel continence monitoring on admission as required. Continence management is then written into the care plan. Catheter management plans are in place for residents with indwelling catheters. Specialist continence advice is available as needed and the clinical manager on duty could describe the referral process. There are adequate supplies of continent products in all areas.    Residents’ weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated. Interventions for unintentional weight loss include more frequent weight monitoring (as instructed), dietary supplements, GP notification and dietitian referral. The speech language therapist is readily available by referral for swallowing difficulties.  Pain assessments are completed and reviewed at least every six months for residents on regular and prn pain relief. Pain assessments and pain monitoring is completed for all new episodes of pain or exacerbation of chronic pain. Pre and post analgesia pain relief monitoring occurs. A pain management plan is sighted for a resident on controlled drugs for pain relief. The GP reviews pain relief at least three monthly.    D18.3 and 4; Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employs an activity supervisor (diversional therapist in training) and three activity co-ordinators to implement an activity programme across all areas Monday to Friday from 8.30am to 3.30pm. Staff have access to activity resources for weekends. The activity staff attend local diversional therapist support groups, conference and on-site in-services. There are three activity staff on each day who provide a variety of activities that are rotated to occur in all 12 areas at different times of the day. Residents have a choice of integrated group activities to attend. There are higher functioning group activities that includes rest home residents. The rest home residents are currently involved in a recycling project in conjunction with Unitech, who supply old files that require sorting and shredding. The shredded paper is donated to SPCA and the zoo. A recent newspaper article led to the donation of a shredder for the residents. There is a set annual planner around theme days and festive occasions. Community visitors include (but not limited to); monthly church services, weekly catholic communion, visiting library bus, brownies, school children, pet therapy, RSA, beautician (fortnightly) and guest speakers. There are a variety of entertainers who visit the home. Green prescription exercises include seated, standing and strengthening exercises. The activity team have a portable keyboard and guitar and provide sing-a-longs and music in each of the lounges. Other activities include garden and facility walks, relaxation therapy, floor games, bingo, artworks, word games and reminiscing. There are two van outings a week to gardens, community functions, mystery drives and recently to see the tall ships. The activity staff have current first aid certificates. One on one therapy and activity time is spent with residents whole are unable to participate in group activities or choose to stay in their rooms. A social leisure profile and spiritual/cultural needs assessment is completed as part of the resident assessment on admission. An activity plan is developed within three weeks of admission. The activity plan is reviewed every six months at the same time as the care 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The long term care plan is developed within three weeks of admission and evaluated at least six monthly or if there is a change in health status. The review involves the RN, resident care co-ordinator, activities supervisor and resident/family/whanau as appropriate. Nine of eleven resident files sampled (on Leecare system) evidenced at least six monthly evaluations. Two hospital residents had not been at the service six months. Short term acute care plans are evaluated and resolved or added to the long term care plan if the problem is on-going. The GP examines the resident at least three monthly and completes a medication review.   D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c; All initial care plans are evaluated by the RN within three weeks of admission. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical manager and RNs are able to describe the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted are to needs assessment service coordination (NASC), dietitian, speech language therapist, physiotherapist, mental health services, and ophthalmology, plastic surgeon, endoscopy and urology services. The GP (interviewed) discusses specialist referrals and options for treatment with the resident/family/whanau as appropriate.  D16.4c: One rest home file sampled provided evidence of the service initiating a re-assessment for higher level of care. The needs assessment outcome for the resident remained at rest home level of care.  D 20.1; Discussions with the registered nurses and clinical manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, gerontology nurse specialist , dietitian , occupational therapist and physiotherapist. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept with the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.  The RNs communicate with family/EPOA regarding transfers and updates on the residents' condition. |

##### **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.

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medication policies and procedures align with accepted guidelines. Medications are stored safely in locked rooms within in the six wings. The supplying pharmacy deliver the robotic rolls and prn blister packs. There is no formal medication reconciliation on delivery of medications. All returns are stored safely until collected by the pharmacy.  RN’s and senior HCAs complete annual medication competencies and attend annual medication education. RNs have completed syringe driver competency. There is a current signing register of all mediction competent staff. There are no self medicating residents. The standing orders in use are current. Verbal orders are signed on the medication chart within two days. Medication fridges are monitored weekly and recordings sighted are within an acceptable range. All eyedrops in use are dated on opening. Controlled drug (CD) registers evidence a weekly CD check. Two staff sign for the administration of CDs’.  All drug adminstration sheets are correctly signed. PRN medications administered have the date and time recorded on the signing sheet. There is transcribing of prn medications on 12 of 22 medication non-packaged signing sheets.  22 medication charts sampled all had photo identification and allergies noted. Ten of 22 medication charts do not have indications for use of prn medications. |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medications are stored safely in locked rooms within in the six wings. The supplying pharmacy deliver the robotic rolls and prn blister packs. RN’s and senior HCAs complete annual medication competencies and attend annual medication education. PRN medications administered have the date and time recorded on the signing sheet.  22 medication charts sampled all had photo identification and allergies noted. |
| **Finding:** |
| (i)There is no formal medication reconciliation on delivery of medications. (ii) There is transcribing of prn medications on 12 of 22 medication non-packaged signing sheets. (iii) Ten of 22 medication charts do not have indications for use of prn medications. |
| **Corrective Action:** |
| (i)A medication reconciliation form is developed on the day of audit to be implemented with the next delivery of medication; (ii) Transcribing of prn medications to cease. (iii) PRN medications require an indication for use on the medication chart. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The hospitality manager oversees the food services. There are two cooks and two kitchenhands on duty that work staggered hours to cover the meal times and cleaning duties. There is a four weekly menu. All cooking and baking is done on-site. The main meal is at midday with a lighter evening meal. The menu is reviewed by the dietitian. Resident meetings allow the opportunity for resident feedback and suggestions on the meals. The new menu was introduced in July 2013. A meal survey resulted in improved resident satisfaction. The kitchen receives a resident dietary requirement list for new admissions and a dietary request form for any changes to residents nutritional requirements, such as supplements and high caloorie foods for weight loss. There are nutritious snacks that can be accessed by the RN’s after hours as required for residents. The cooks accommodate ethnic needs, resident dislikes and accommodate normal and soft/pureed meals. Meals are delivered plated and in hot boxes to each unit. End cooked temperatures are monitored by the combi oven probes and linked to an online data base. The kitchen is well equipped with a good work flow. All equipment has been checked and display electrical test and tags. All foods are dated in the fridges and chiller. Dry goods in the pantry are off the floor, dated and sealed. The chemical supplier completes monthly quality control checks on the dishwasher and autofeed systems. Chemicals are stored safely after hours. Kitchen staff are observed to be wearing appropriate protective clothing.  D19.2 staff have been trained in safe food handling. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms have hand basins. Half of the facility bedrooms have en-suites. There are adequate numbers of communal toilets and showers in each wing. There is safe flooring and handrails appropriately placed in the toilets and shower rooms. There are privacy curtains and privacy locks. Residents interviewed (two rest home and five hospital) confirmed that staff provide the resident with privacy when attending to personal hygiene cares. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms are single and spacious enough for residents to manoeuvre freely about the room with the use of mobility aids. All beds are electric. HCAs confirmed on interview there is adequate space to safely deliver care with the use of hoists and other transferring equipment for hospital level residents. Residents and family/whanau are encouraged to personalise their bedrooms. Relatives/whanau (two rest home and five hospital) and residents interviewed confirm their bedrooms are of adequate size and they can personalise them as they like. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a large open plan lounge and dining room with outdoor access on the ground floor. Each wing has a kitchenette with an open plan dining/lounge area. Activities occur throughout the facility in all lounges. There is one lounge that can open out into a large area for entertainment and other large group activities. Residents are able to move freely both with and without assistance throughout the audit and resident’s interviewed report they can move around the facility and staff assist them if required.  D15.3d; Seating and space is arranged to allow both individual and group activities to occur. |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a laundry manual and cleaning manual that describes laundry and cleaning processes. There is a well-designed laundry with defined clean and dirty flow and an entry and exit door. The laundry is located away from the resident area and is a secure area. All personal clothing and linen is laundered on site. An iron on labeller was purchased to improve the delivery of clothing to the right residents.  Protective clothing is available including gloves, disposable aprons and goggles. An external chemical supplier provides the chemicals, product use wall charts, conduct quality controls checks and training as required. Chemicals are stored safely. The cleaners trolleys are well equipped and locked in the downstairs chemical cupboard when not in use. The cleaners have a duties and tasks list that includes spring cleaning of rooms, cleaning and checking of wheelchairs, walkers, spot clean of chairs, vaxing of carpets and minor maintenance repairs such as changing light bulbs. Automated air fresheners have been placed in the corridors as a result of a cleaning survey August 2013. A further cleaning audit has resulted in 91% resident satisfaction with cleaning standards. The internal environment is clean and tidy on the day of audit. Residents and families interviewed are very satisfied with the laundry and cleaning service |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An approved evacuation plan was signed off by the New Zealand Fire Services on 27 June 2012. An evacuation policy on emergency and security situations is in place. A fire drill takes place every four to six months. The orientation programme includes fire and security training. Staff (seven healthcare assistants, three registered nurses, one enrolled nurse, two kitchen staff and one activities coordinator) interviews confirm their awareness of emergency procedures.  All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. An external water tank stores 10,000 litres. A three-hour back-up for emergency lighting is in place.  An electronic call bell system (Austco) is in place. Call bells are located in all residents’ rooms, toilets and lounge/dining areas. A report is generated that reflects response times to call bells. Evidence of corrective actions are undertaken when call times exceed what is expected (one minute per resident and three minutes for a monthly average).  Staff are trained in first aid and hold current CPR certificates. There is a minimum of one staff 24 hours a day, seven days a week holding a current CPR certificate. The facility is surrounded by a gate, which is locked at 6:30pm. Latches are on all upstairs windows. External lighting is adequate for safety and security. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms and communal areas have external windows allowing adequate natural light into the rooms. Opening windows with security stays allow adequate ventilation. There is a fresh air ventilation system in the newer part of the building that is thermostat controlled in the nurse’s station. Heating throughout the facility is thermostat controlled through the computer system with the minimum 20 degrees Celsius and the maximum 23 degrees Celsius. This is monitored daily by the CEO. There are heating panels in the bedrooms and corridors. Residents and relatives interviewed stated the temperature of the facility is comfortable. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation and safe practice policies and procedures are in place. Restraint is only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.  The policies and procedures include definitions, processes and use of enablers. Enablers are voluntary and the least restrictive option. Procedures for the use of enablers are the same as procedures for the use of a restraint. Restraint training is included in the induction programme and in-service education programme and includes staff completing a competency questionnaire.  Strategies are in place to minimise the use of restraint including strategies to manage challenging behaviours and keep residents engaged in activities, regular (one-hourly and two-hourly) toileting and signage where appropriate. At the time of the audit, there were no residents using an enabler. |

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

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

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint coordinator’s role is shared between the quality manager and registered nurse supervisor. The restraint approval group is the clinical management group. Restraint is used only as a last resort. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two residents’ files where restraint is being used were selected for review. A falls assessment form is currently being used to determine if restraint use is indicated. This is completed by a registered nurse and indicates the need for restraint use, linking any restraint to the residents’ risk of falling. Consent must be given by the family/enduring power of attorney before restraint is implemented. There is one required improvement. A documented restraint assessment process is required. |

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The restraint assessment process is linked to the falls assessment. There is evidence in the clinical documentation of any potential risks relating to restraint use but this is not linked to any restraint assessment process.  Prior to the implementation of an electronic clinical record, a comprehensive, hard-copy restraint assessment form was in place. This restraint assessment form has not been implemented in an electronic format. |
| **Finding:** |
| A comprehensive restraint assessment was previously in place in hard copy and has been discontinued. Indicators for restraint use are determined on the residents’ falls assessment. No restraint assessment is in place either in hard copy or electronically. |
| **Corrective Action:** |
| Ensure a restraint assessment process is implemented which covers all aspects of the criterion. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Services use restraint safely

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation policies identify that restraint is only put in place where it is clinically indicated and justified. Approved restraints include bed rails, hi-lo beds, recliner chairs and lap belts. Monitoring (every two hours minimum) is completed, sighted in two of two residents’ files where restraint is being used.  The service has a restraint and enablers register for the facility. At the time of the audit, 20 residents were using a restraint and no residents were using an enabler. |

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The quality manager and registered nurse supervisor report that residents using restraint are informally reviewed each week during the clinical manager’s meeting. A formal restraint evaluation is completed for each resident using a restraint (or enabler) following the initial month restraint is put into place and every three months thereafter (evidenced in two of two residents’ files). The use of a restraint or enabler is linked to the residents’ care plans (evidenced in two of two residents’ files). |

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

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

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service actively reviews restraint as part of the internal audit and reporting cycle. A review of the restraint programme, including staff training, takes place each year by the restraint co-ordinators (quality manager and registered nurse supervisor). Restraint policies were last reviewed in 20 November 2013. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection control programme contained within the IC policy and procedure manual that is appropriate for the size and complexity of the service. Infection control quality goals are included in the quality policy statement 2014 and include evaluating the outcomes of monthly infection control data, ongoing training and contingency plans for outbreaks.  The quality manager and clinical manager share the role as infection control co-ordinators across the faciity. The responsibillity for infection control is clearly defined within the quality manager and clinical manager job descriptions. The infection control co-ordinators provide a weekly report to the management meeting of an overview of infections highlighting any areas of concerns. Staff are made aware of any trends, corrective actions and significant events at handovers.  Infection control is a set agenda item at on all meeting agendas  Visitors are encouraged to stay away if sick. There is a staff health policy in place to ensure staff do not spread infections. The facility has signage to use for outbreaks and displays this information as needed. There are pandemic supplies readily accessible for staff to set up bedrooms and toilets for isolation. There have been no outbreaks since the previous audit. The service links into the northern region health plan. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control co-ordinators attend management and staff meetings. Meeting minutes are sighted. Infection control is a set agenda at every service meeting. The facility also has access to infection prevention and control nurses from the DHB, IC consultants, G.P's and Laboratory services. Internet access is available. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D 19.2a: Ambridge Rose Manor purchased IC policies and procedures from an infection control consultant. The policies and procedures meet current accepted good practice and relevant legislative requirements. The policies are amended as required to meet the type of service provided. The manual includes (but not limited to) policies on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment |

##### **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control co-ordinators have attended infection control seminar at the N.Z. aged care association conference August 2013.  The infection control coordinators are responsible for coordinating and providing six monthly education and training to staff. Records of staff attendence is maintained. Hand hygiene competencies are completed annually. Infection control is included in the orientation of all staff.  The infection control co-ordinators provide brief training sessions at staff meetings for example glove useage, reducing eye infections. Residents and relatives are provided with education on influenza prior to flu vaccinations occurring. Infection control education occurs as appropriate with individual residents. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinators use the information obtained through surveillance to plan and detirmene infection control activities, resources, and education needs within the facility.  Individual infection report forms are completed for all infections and collated each month. Infections are entered onto a monthly data collection and analysis form. Short term care plans are in place for infections. An individual resident infection summary of infection control rates and types are held under the resident file on the Leecare system.  Data collection, trends and analysis are reported to the management meeting. Staff receive an infection report and graphs with numbers of infecitons. Standardised definitions of infections are in place and are appropriate to the complexity of service provided. Infection surveillance includes eye, cellulitis, UTI, respiratory, wound and other infections. Antibiotic use is monitored and reported to the GP. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Remedies are developed when needed and CARS are put in place. In January 2014 eye infections had increased tor individual six across the facility. The service purchased new eye trays for individual residents and set up sterilizing units for the trays. Staff were informed of the concern and the use of the trays. The following month (March 2014) there were zero eye infections. The service has 92 hospital level residents many of whom are dependent on staff for all cares. The reduction of eye infections to zero demonstrates excellent infection control practice. The quality improvement introduced of individual eye trays has significantly reduced the eye infections to zero. Internal audits occur as scheduled. |

##### **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.

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| **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.

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