# Avatar Management Limited

## Current Status: 31 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

The Maida Vale Retirement Village complex includes rest home and hospital level of care services. These services are provided in three separate buildings: Woodrow Grove is mainly hospital level of care with some rest home and younger adult residents; Mountain View is a mix of rest home and hospital level of care, with some independent living units; and the Ocean View apartments are mostly independent living units, where some residents receive rest home level of care. At the time of audit there are 77 residents (39 hospital level of care and 38 rest home level of care), which includes five younger adults under the age of 65 years.

There are three areas identified as requiring improvement to meet the Standards. These are related to the follow-up from adverse events, the updating of assessments, and ensuring the assessment process is used when making changes to the care plan. There are two areas of continuous improvement (areas that are rated beyond full attainment level) for the organisation’s implementation of strategies to reduce the use of restraint, and the development and implementation of a tracking system for residents who have the potential to wander.

## Audit Summary as at 31 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 31 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. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 31 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 31 March 2014

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

### Safe and Appropriate Environment as at 31 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 31 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. |  | All standards applicable to this service fully attained with some standards exceeded |

### Infection Prevention and Control as at 31 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 31 March 2014

### Consumer Rights

The service has processes in place that demonstrate their commitment to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident’s independence and reflects the residents’ and their families/whanau wishes. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural, values and beliefs are provided at the service.

Residents receive services of an appropriate standard for rest home and hospital level of care. The service provides an environment that encourages good practice. The service has conducted a number of projects that reflect current accepted good practice; this is an area that the service has received a continuous improvement rating, that is, above the expected full attainment. The resident, family and the general practitioner express high satisfaction with the quality of care at Maida Vale Retirement Village.

Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff are demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

Residents and family members are aware of the complaints process. Complaints are reported, investigated and followed up in a timely manner.

### Organisational Management

Maida Vale Retirement Village has a documented organisation mission, vision and philosophy which incorporate their 'Best Care' philosophy into all aspects of service delivery. The organisation is managed by a Board of Directors who review the scope and provision of services annually. Two of the directors work in the facility, and this includes the role of the owner director who has worked in the residential aged care setting for 44 years. The clinical services manager is responsible for ensuring the day to day care needs of the residents are being met.

Maida Vale Retirement Village has a quality and risk programme in place which includes compliment and complaints management, hazard identification, risk management, internal audits, benchmarking indicators with other health services (in Australia and New Zealand), and additional external quality accreditation programmes for the housekeeping and catering services. The service has retained tertiary level in the workplace safety programme with the Accident Compensation Corporation (ACC).

There is a focus on on-going quality improvement and staff training/education. Where shortfalls are identified, the service implements a corrective action planning process. The incident and accident reporting and investigation process is linked through the quality and risk system. Not all areas requiring improvement are actioned in response to reported incidents. The analysis of incident data is not as detailed since November 2013. These are areas requiring improvement.

The service provides a comprehensive orientation and ongoing in-service education programme for all levels of staff. This includes via the Avatar Learning Institute (operated on site) which is registered with the New Zealand Qualifications Authority (NZQA) to provide an industry approved qualification in residential care.

The rosters show adequate staffing levels to meet resident numbers and care needs. There are at least two registered nurses on duty at all times.

Resident records are sufficiently detailed, meet current industry standards, are integrated and stored securely.

### Continuum of Service Delivery

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for rest home or hospital level care and a bed is available.

Maida Vale has systems and processes implemented to assess, plan and evaluate the care needs of the residents. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. There is a clinical service manager who oversees the care and management of all residents along with a charge nurse/registered nurse in each clinical care area.

Assessments are appropriate and based on good practice. The residents’ care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed on a regular basis, six monthly or more often as required, with resident and family/whanau input being sought. Short term care plans are used as required to guide service delivery for residents who have short term needs. Two areas require improvement related to ensuring re-assessment timeframes are met to meet policy requirements and that evaluation information is informed by assessment processes where relevant.

The service provides planned activities for all age groups and acuity levels and residents are fully involved in this process to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. There are group and one to one activities provided for the rest home, hospital and younger residents.

Residents receive medicines in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertakes medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements and residents’ likes and dislikes. The kitchen service has external compliance inspections regularly conducted.

### Safe and Appropriate Environment

The emergency response processes which are clearly documented and regularly reviewed are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery.

Six monthly fire evacuations and on-going emergency education is undertaken to ensure all staff understand how to deal with an emergency situation. All three buildings have a current building warrant of fitness and approved fire evacuation plans.

The facilities are fit for purpose and provide furnishings and equipment that are maintained to a high standard and are appropriate and accessible for rest home and hospital level care residents. Bedroom and bathroom areas meet legislative requirements and residents confirm they are very happy with their personalised bedrooms. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is centrally heated and is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use. Residents have access to well-maintained outdoor areas with appropriate seating and shelter.

Having fully attained standard 1.4.7.6 the service can in addition clearly demonstrate a review, analysis and monitoring process which has gained a continued improvement rating.

### Restraint Minimisation and Safe Practice

The organisation is actively working to minimise the use of restraint, and has gained a continuous improvement rating for this. There is evidence that all possible alternatives are tried before implementing restraint as a last resort. There are six residents assessed and approved for use of restraint for safety and comfort. Where enablers are used these are voluntary and the least restrictive option for the resident to maintain their safety, comfort and independence. The service has ongoing quality review of the restraint use for both individual residents and the overall restraint use throughout the service.

### Infection Prevention and Control

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually, with input from an external infection prevention and control advisor. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up.

The service’s policies and procedures are developed by an external specialist organisation and comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau.

There is a monthly surveillance for infections. The surveillance data is collected, collated and analysed monthly. The Woodrow Grove data is benchmarked quarterly with an external provider, with other surveillance results benchmarked internally. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections.

# 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:** | Avatar Management Limited |
| **Certificate name:** | Avatar Management Limited |

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| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

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| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Maida Vale Retirement Village |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical |
| **Dates of audit:** | **Start date:** | 31 March 2014 | **End date:** | 2 April 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:** | 77  |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 24 | **Hours off site** | 12 |
| **Other Auditors** | XXXX & XXXXX | **Total hours on site** | 24 | **Total hours off site** | 16 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 5 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 48 | Total audit hours off site | 33 | Total audit hours | 81 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 14 | Number of staff interviewed | 26 | Number of managers interviewed | 6 |
| Number of residents’ records reviewed | 11 | Number of staff records reviewed | 11 | Total number of managers (headcount) | 7 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 113 | Number of relatives interviewed | 9 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## Declaration

I,XXXXX , of hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group 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 The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group 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) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Friday, 9 May 2014

## Executive Summary of Audit

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| **General Overview** |
| The Maida Vale Retirement Village complex includes rest home and hospital level of care services. These services are provided in three separate buildings: Woodrow Grove is mainly hospital level of care with some rest home and younger adult residents; Mountain View is a mix of rest home and hospital level of care, with some independent living units; and the Ocean View apartments are mostly independent living units, where some residents receive rest home level of care. At the time of audit there are 77 residents (39 hospital level of care and 38 rest home level of care), which includes five younger adults under the age of 65 years. There are three areas identified as requiring improvement to meet the Standards. These are related to the follow-up from adverse events, the updating of assessments, and ensuring the assessment process is used when making changes to the care plan. There are two areas of continuous improvement (areas that are rated beyond full attainment level) for the organisation’s implementation of strategies to reduce the use of restraint, and the development and implementation of a tracking system for residents who have the potential to wander.  |

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| **Outcome 1.1: Consumer Rights** |
| The service has processes in place that demonstrate their commitment to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility. Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident’s independence and reflects the residents’ and their families/whanau wishes. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination. Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural, values and beliefs are provided at the service. Residents receive services of an appropriate standard for rest home and hospital level of care. The service provides an environment that encourages good practice. The service has conducted a number of projects that reflect current accepted good practice; this is an area that the service has received a continuous improvement rating, that is, above the expected full attainment. The resident, family and the general practitioner express high satisfaction with the quality of care at Maida Vale Retirement Village. Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff are demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.Residents and family members are aware of the complaints process. Complaints are reported, investigated and followed up in a timely manner. |

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| **Outcome 1.2: Organisational Management** |
| Maida Vale Retirement Village has a documented organisation mission, vision and philosophy which incorporate their 'Best Care' philosophy into all aspects of service delivery. The organisation is managed by a Board of Directors who review the scope and provision of services annually. Two of the directors work in the facility, and this includes the role of the owner director who has worked in the residential aged care setting for 44 years. The clinical services manager is responsible for ensuring the day to day care needs of the residents are being met.Maida Vale Retirement Village has a quality and risk programme in place which includes compliment and complaints management, hazard identification, risk management, internal audits, benchmarking indicators with other health services (in Australia and New Zealand), and additional external quality accreditation programmes for the housekeeping and catering services. The service has retained tertiary level in the workplace safety programme with the Accident Compensation Corporation (ACC).There is a focus on on-going quality improvement and staff training/education. Where shortfalls are identified, the service implements a corrective action planning process. The incident and accident reporting and investigation process is linked through the quality and risk system. Not all areas requiring improvement are actioned in response to reported incidents. The analysis of incident data is not as detailed since November 2013. These are areas requiring improvement.The service provides a comprehensive orientation and ongoing in-service education programme for all levels of staff. This includes via the Avatar Learning Institute (operated on site) which is registered with the New Zealand Qualifications Authority (NZQA) to provide an industry approved qualification in residential care. The rosters show adequate staffing levels to meet resident numbers and care needs. There are at least two registered nurses on duty at all times.Resident records are sufficiently detailed, meet current industry standards, are integrated and stored securely. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for rest home or hospital level care and a bed is available.Maida Vale has systems and processes implemented to assess, plan and evaluate the care needs of the residents. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. There is a clinical service manager who oversees the care and management of all residents along with a charge nurse/registered nurse in each clinical care area. Assessments are appropriate and based on good practice. The residents’ care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed on a regular basis, six monthly or more often as required, with resident and family/whanau input being sought. Short term care plans are used as required to guide service delivery for residents who have short term needs. Two areas require improvement related to ensuring re-assessment timeframes are met to meet policy requirements and that evaluation information is informed by assessment processes where relevant.The service provides planned activities for all age groups and acuity levels and residents are fully involved in this process to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. There are group and one to one activities provided for the rest home, hospital and younger residents. Residents receive medicines in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertakes medicine administration hold appropriate competencies.Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements and residents’ likes and dislikes. The kitchen service has external compliance inspections regularly conducted.  |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The emergency response processes which are clearly documented and regularly reviewed are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Six monthly fire evacuations and on-going emergency education is undertaken to ensure all staff understand how to deal with an emergency situation. All three buildings have a current building warrant of fitness and approved fire evacuation plans.The facilities are fit for purpose and provide furnishings and equipment that are maintained to a high standard and are appropriate and accessible for rest home and hospital level care residents. Bedroom and bathroom areas meet legislative requirements and residents confirm they are very happy with their personalised bedrooms. The dining and lounge areas meet residents' relaxation, activity and dining needs. The facility is centrally heated and is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use. Residents have access to well-maintained outdoor areas with appropriate seating and shelter. Having fully attained standard 1.4.7.6 the service can in addition clearly demonstrate a review, analysis and monitoring process which has gained a continued improvement rating. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The organisation is actively working to minimise the use of restraint, and has gained a continuous improvement rating for this. There is evidence that all possible alternatives are tried before implementing restraint as a last resort. There are six residents assessed and approved for use of restraint for safety and comfort. Where enablers are used these are voluntary and the least restrictive option for the resident to maintain their safety, comfort and independence. The service has ongoing quality review of the restraint use for both individual residents and the overall restraint use throughout the service.  |

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| **Outcome 3: Infection Prevention and Control** |
| Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually, with input from an external infection prevention and control advisor. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The service’s policies and procedures are developed by an external specialist organisation and comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau. There is a monthly surveillance for infections. The surveillance data is collected, collated and analysed monthly. The Woodrow Grove data is benchmarked quarterly with an external provider, with other surveillance results benchmarked internally. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. |

## Summary of Attainment

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 46 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 2 | 96 | 0 | 2 | 1 | 0 | 0 |

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

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting  | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | The staff are reporting incidents and accidents as required by the organisational policy. It is not always evident that all areas requiring improvement are identified and addressed. For example a resident has four incident reports for skin tears and two include episodes of challenging behaviour. Individual wound plans are developed for the skin tears, but there is no evidence that the challenging behaviour components have been actioned. There is a monthly form for the number and types of incidents per category, per building to be analysed. Since November 2013 the analysis data only relates to falls. | Ensure that all areas that are identified in response to an incident are actioned. Ensure the incident/accidents analysis includes all types of incidents reported.  | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Three of the four file reviews undertaken at Woodrow Grove show that the six monthly timeframes are not always met. The timeframes range between seven and nine months between re-assessments. Residents changing needs are shown on the care plan but not supported by appropriate assessment).  | Ensure assessment timeframes are met as per policy requirement and to support changes to care plans. | 180 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment  | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Initial assessments identify all resident needs. However not all ongoing needs or changing needs are informed by the assessment process. Changes are made to the care plans to reflect residents’ changing needs but they are not informed by the assessment process. Examples sighted relate to behaviour management, mobility, falls risk ratings and skin integrity. | Ensure changes to interventions are informed by use of appropriate assessment tools. | 180 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.4.7.6 | The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting. | CI | The Avatar Trakakiwi security system has been developed via use of iPhone technology and has set safe parameters that residents can move around in. If the resident goes to the edge of the perimeter and is at risk of exiting the grounds an alarm alert is triggered on the units carried by staff and they are informed where the resident is. They can then guide them back to the areas within safe limits. This project has been closely monitored and involved staff from all areas. Evaluation identifies there have been no incidents of residents who ‘wander’ leaving the grounds since its inception. |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised.  | CI |  |
| HDS(RMSP)S.2008 | Criterion 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. | CI | The organisation’s achievement for actively minimisations of restraint use is beyond the expected full attainment. The organisation has conducted a number of projects and quality reviews of the restraint minimisation and safe use practices, which include analysis and reporting of findings. There is documented evidence of action taken based on findings and improvement to service provision and the safe and appropriate minimisation of restraint use. The residents’ safety has been measured as a result of the review process, which indicates there has been no falls as a result of the removal of the restraints.  |

# 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:** |
| As part of the audit a total of 26 staff and six managers are interviewed. The staff interviews consisted of 16 direct care staff (three registered nurses (RNs), two enrolled nurses (ENs) and 11 caregivers), and 10 additional staff members (one physiotherapist, one recreational officer, one restraint coordinator, one infection control officer, one maintenance/grounds person, one head gardener, one cook, one cleaner, one training school tutor and one receptionist). The care staff are from the rest home and hospital sections and cover staff from all shifts (morning, afternoon and night). As observed on the days of audit staff incorporates aspects of consumer rights into everyday practice. They knock on doors before entering residents’ bedrooms, use residents’ preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (16 of 16 direct care staff from across all services) confirm they respect the resident’s right to refuse cares or interventions. Staff can verbalise ways they deal with situations that arise which ensure residents’ rights are maintained. This is confirmed during interviews with 14 of 14 residents (seven rest home and seven hospital, including one younger person under the age of 65) and nine of nine family/whānau members. The general practitioner (GP) interviewed reports that the resident’s rights are respected at Maida Vale. The Age Related Residential Aged Care (ARRC) requirements are met. |

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

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

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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:** |
| Opportunities are provided for explanations, discussion, and clarification about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) with the resident and family/whānau as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service are clearly displayed at the entrances to the facility (Ocean View apartments, Mount View and Woodrow Grove) and available to residents and visitors. Each resident room has an information brochure on the Code and the complaints form (as confirmed in the residents’ rooms visited during audit). Interviews with 14 of 14 residents and nine of nine family/whānau report they are informed of their rights and that staff always respect all aspects of their rights.ARRC requirements are met. |

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

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

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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:** |
| Stage one: The Clients Rights policy sighted documents that residents are to be kept safe and are not subjected to, or at risk of, abuse and/or neglect. The service has a policy on sexuality and intimacy in aged care that is linked to a District Health Board (DHB) procedure. Stage two: The environment allows residents physical, visual, auditory and personal privacy. All the apartments in Ocean View sections are single occupancy/owner occupied apartments; Mountain View have three rooms that can be double occupancy (eg, for married couples); and there is one shared room in the Woodrow Grove sections. The shared room in Woodrow Grove has privacy curtains that provide adequate privacy for each of the residents. Resident’s needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in 11 of 11 resident file reviews (five rest home and six hospital including one younger person), which identify interventions put in place to encourage or maximise the resident’s independence. As observed at the time of audit services are provided in a manner that maximises each resident’s independence and allows choices to be respected. The 14 of 14 residents and nine of nine family/whānau interviewed report that they are treated with respect and that resident receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. The family added comments that they are ‘amazed by the caringness’ of all staff and that the service has ‘exceeded all expectations’ regarding the quality of care provided. One resident interviewed reports that their independence is encouraged and that they have an electric scooter so that they can go out independently. |

##### 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:** |
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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 1.1.4: 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:** |
| Stage one: The sighted Māori Health plan is based on the He Korawai Oranga-Maori Health Strategy. Maida Vale Māori Health Development Plan 2012 -2015 is sighted and records the performance objects that include; all staff will have an understanding and awareness of Māori as the Crown’s Treaty partner; Maida Vale will meet the needs of Māori Residents; consultation with Iwi and linkages; reducing barriers; availability of Māori staff; and education. Stage two: Māori residents have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. The clinical services manager reports there are no barriers to Māori accessing the service and there have been a number of Māori residents at the service in the past and there are currently Māori staff at the service. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interviews with care staff interviewed from across all services. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. The care staff report that there is one resident, who is Maori, though this person does not identify as Maori. The ARRC requirements are met.  |

##### 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:** |
| Stage one: The sighted policies and procedures adequately address cultural and spiritual aspects of care, to ensure the resident’s cultural needs are met through assessment, care and regular review/evaluation. A cultural assessment will be used to inform staff of the resident’s day-to-day preferences in relation to physical, social and mental/emotional health needs. Stage two: Interviews with 14 of 14 residents (seven rest home and seven hospital, including one younger person under the age of 65) and nine of nine family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care plan (as sighted in 11 resident file reviews). The ARRC requirements are met. |

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

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

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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:** |
| The 11 of 11 staff record reviews identify that staff sign a code of conduct that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with 26 of 26 staff, 14 residents, one GP, and nine family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. |

##### 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:** |
| The organisation operate a training school, which is linked to the ongoing education programme for the staff, with the care staff having access to national level three qualifications. There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interview with the care staff report that they have input into the topics that they wish to receive further education on. The RNs and ENs have access to ongoing education programmes offered through the DHB. Interviews with the 26 of 26 staff confirm that the environment in which they work encourages good practice.The organisational policies and procedures are referenced to and linked to a best practice institute. The organisation has access to and input from external specialist and advisors from the DHB and an external aged care consultant for the review of clinical practices and care planning. Interviews with 14 of 14 residents (seven rest home and seven hospital, including one younger person under the age of 65); nine of nine family/whānau and the GP confirm their high level of satisfaction with all care delivery and staff attitudes.  The relevant ARRC requirements are met. |

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

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

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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 resident and family member’s right to open disclosure is explicit within policy documents sighted. Open disclosure is sighted as occurring in response to adverse events/incidents and changes in residents’ health condition in eleven of eleven resident files sighted during audit. All fourteen residents and all nine family members interviewed confirm they are kept fully informed of all changes and events. Open disclosure is documented on the incident reports and in the resident files sighted.There are currently no residents who require a translator. The owner/director (OD) and one registered nurse (RN) interviewed are able to identify the process for accessing a translator if this is required. The process is also included in policy documents sighted. The owner director advises all overseas trained Registered Nurses employed are provided with the contact details of Settlement Support Services Taranaki. The OD advises this organisation provides very good supports if required.ARRC contract requirements are met. |

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

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

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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:** FA |
| **Evidence:** |
| Stage one: The sighted Giving Information and Consent policy outlines the process for clinical staff members to obtain informed consent from residents and/or their personal representatives for each treatment, therapy, procedure or preventative strategy being proposed by the clinical staff members. The advance directive policy complies with requirements. Stage two: Signed consent forms are sighted in the eight of eight residents’ files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with 14 of 14 residents (seven rest home and seven hospital, including one younger person under the age of 65) and nine of nine family/whānau members. The 11 of 11 residents’ files reviewed have correctly signed advanced directives or an advance care plans identifying the resident’s chosen wishes related to resuscitation status and end of life care. The 16 of 16 direct care staff demonstrate their understanding of acting on valid advance directives. ARRC requirements are met. |

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

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

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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:** 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 1.1.11: 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:** |
| The 11 of 11 residents’ files reviewed, interviews with 14 of 14 residents and nine of nine family/whānau confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family/whānau members confirm their awareness of where to locate the information. ARRC requirements are met. |

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

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

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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:** |
| Interviews with 14 of 14 residents (seven rest home and seven hospital, including one younger person under the age of 65) confirm they have access to visitors of their choice. The nine of nine family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours. Three of the younger persons have support and planned activities from a community organisation related to their diagnosis.Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in 11 of 11 residents’ files identifies that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. For example weekly RSA visits regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended service in the community. ARRC requirements are met. |

##### 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:** |
| Stage one: The services comments/compliments/complaints policy and linked complaints brochure complies with right 10 of the Code. The complaints policy is currently under review and a draft of the revised version sighted on the ‘red hot notice board’ with invitation for staff to review and provided feedback.A complaints register is being maintained and sighted. The register aligns with the business financial year 1 April 2013 to 31 March 2014. The 2014 complaints register commencing 1 April 2014 also sighted. A review of five complaints from the complaints registers, including those related to staffing, timeframes to answer call bells, food services, and a wandering resident, demonstrates complaints are acknowledged, investigated and followed up in timeframes to meet the Code. At times the communication occurs via letter or email. For other complaints the communication occurs verbally and a summary of these discussions is documented.An electronic register is also maintained which categorised the complaints per resident care unit. Complaints and compliments are discussed as a component of the monthly continuous quality improvement/risk management meeting and this is verified in minutes sighted.The owner director advises there have been no complaints to the Health and Disability Commissioner (HDC), Accident Compensation Corporation (ACC),) and Ministry of Health (MOH) since the last audit.All nine family members and all fourteen residents are aware of the complaints process as confirmed during interview. Information is provided to new residents and family as a component of the admission process. One resident advises having made several complaints and all have been fully addressed. The resident is able to discuss the complaints resolution process in detail. Information on the complaints process is also well known by the 26 staff (including care staff and non-care staff) interviewed. |

##### 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 leadership and management manual (updated March 2014) identifies all services provided within the facility. The mission statement is ‘to provide a homely professional environment in which Maida Vale residents live, assured of quality, compassionate care in safe surroundings, promoting physical wellbeing and emotional security.The philosophy is ‘best care’ and organisation values are listed using the ‘best care’ acronym.The organisation goals and plans are identified in the quality and risk plan (April 2014). The board of directors (BOD) are responsible for the development of the strategic plan with action points and timeframes. The current strategic plan is for April 2013 to March 2017 period and this is sighted. Staff is reported to have the opportunity to contribute to the review and planning processes. This includes by the development of an annual ‘wish list’.The owner director (OD) has been working in the aged care industry for 44 years and has owned and managed three aged care residential facilities (including Maida Vale). The OD is responsible for the day to day operations of the facility and is normally on site seven days a week. The OD is one of three directors. The OD is also one of the two privacy officers. The OD attends relevant ongoing education and records of this are sighted.The clinical services manager has been in the role since January 2013 initially in a job share capacity. She is a RN with a current annual practising certificate (APC) and this is sighted. Prior to this the CSM worked as a registered nurse in a variety of settings including mental health, oncology, and haematology and as a RN in this facility. The CSM job description details the CSM responsibilities as defined in the ARRC contract and includes ensuring the day to day care needs of the residents are met. The CSM attends more than eight hours of education a year in relation to managing a residential aged care facility and records sighted. The education includes InterRAI training, managing staff performances, legal issues and assorted clinical issues. A letter sighted from HealthCERT verifies the CSM is ‘suitably qualified and experienced’ for the role sighted.ARRC contract requirements are met. |

##### 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 CSM absence one of the two charge nurses is allocated the responsibility of oversight of clinical care. The charge nurse (CN) started as a RN in August 2011 and was appointed to the CN role in 13 December 2013. The CN maintains a current APC and this is sighted. The CSM is developing a list of responsibilities to be covered by the CN in the event of her absence. This CN is also responsible for a number of clinical quality projects. The CSM states the OD and other members of the management team are available to support the CN as required. The OD confirms that the CSM and OD will never be on leave at the same time.The CN interviewed is aware of the responsibilities held in the CSM absence and feels well supported. The CSM advises a communication is provided to all staff alerting them to the fact the CN is covering for the CSM role. |

##### 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:** |
| Stage one: The disaster plan, hazard register, pandemic plan and safe environment documents identify actual and potential risks. The hazard register identifies the hazard, rates the hazard, records if the hazard can be eliminated, isolated or minimised and how the hazard is to be monitored and reviewed. Stage two: There is a quality and risk management plan which details goals and objectives for the coming year. Included are a range of key performance indicators, how these will be measured and the target rates set.Policies and procedures have been reviewed and updated by the owner/director (OD). The OD is responsible for document control processes and has editing rights for electronic policies and procedures. There are between one and three paper copies of manuals available for staff. A register is maintained which details the name of the manual and where these are held. The review date for policies is scheduled and all policy documents sighted have been reviewed in the past year. The OD demonstrated that electronic copies are available for staff as read only. Most staff however are reported to refer to the paper based copies. The policies include hyperlinks to reference material, legislation, and forms. The source of information is identified. Staff are not allowed to print forms in the units but rather send a request to the receptionist (on a template form) requesting copies of specified forms. The clinical area has minimum and maximum numbers of forms to be kept in the unit. This process is sighted to be implemented during audit to ensure the current version of forms is in use. New resident files are developed for potential admissions by administration staff ensuring the current version of clinical documentation is included.Twenty-six staff interviewed (eleven caregivers, two enrolled nurses, three RNs, physiotherapist, recreation officer, cleaner, cook, maintenance/grounds man, head gardener, receptionist, infection prevention and control nurse, the educator, and the restraint coordinator) confirm there are effective ways to communicate quality and risk issues. This includes via the ’red hot’ notice board. Staff are required to review this noticeboard at least every shift for updated memos, copies of draft policies, and updates on key topics. These noticeboards are sighted in all units and contain current relevant information.In addition there are three monthly staff meetings. Minutes of the last two meetings held incudes discussion on quality and risk issues including audit results, incident data, complaints/compliment and health and safety issues. There are weekly management meetings. Minutes of meetings held since 11 March 2014 are sighted and include topics/issues that the management team ‘need to know’. The continuous quality improvement (CQI) and risk committee meets monthly. The risk management adviser for Taranaki DHB attends the meeting on a three monthly basis and this is documented in minutes sighted. Minutes of the last three CQI meetings evidences discussion includes (but is not limited to): contacts held, legislative compliance, compliments/complaints, education/training, resident infection rates, antimicrobial usage, and reports from the household services, recreation officer, the training school and the two charge nurses (CNs). The CN reports include discussions on changes in occupancy and projects. Also discussed at the CQI meetings are audit results (internal and external), satisfaction survey results, restraint use, maintenance reports and incidents/accidents and falls for each unit. A CQI meeting was not held in January 2014.A number of internal audits are completed. The schedule of audits and when they are to be completed is sighted. A review of nine audits selected at random from the schedule (includes controlled drugs audit, infection control/environmental, contractor compliance, medication audit, kitchen audit, staff file audit and several clinical record audits) identifies audits are completed as planned using template audit tools. The results are analysed and communicated to staff and managers. The results of the six monthly hazard review audits in each building are also sighted. The results are tabled along with corrective action plans where required. Where improvements are required a corrective plan is documented, implemented and monitored for effectiveness. In addition food services and laundry services are audited by an external auditor on at least an annual basis and records of this are sighted.A resident satisfaction survey is conducted annually. The results are submitted to an Australian company for benchmarking. A satisfaction survey has just been completed however the data not yet submitted for benchmarking. The results are analysed per building and indicates there is a good level of satisfaction with services provided. The evening meals are commented on as an area which could be improved. Residents under 65 years of age meet for a monthly residents’ meeting and rest home level care residents meet monthly for a residents’ meeting. Hospital level care residents meet for a residents’ meeting three monthly. Minutes are maintained of each meeting.A range of adverse events/incident data for events reported within one of the buildings is provided to an external organisation for inclusion in a benchmarking programme. The results are reported as indicators quarterly. The results sighted for the period ending December 2013 identifies that Maida Vale features within the top two quartiles for twelve of the fourteen indicators monitored. The two indicators where Maida Vale featured in the third or fourth quartile relates to staff injuries and resident skin tears. The OD and CSM advises that while the data included in the benchmarking programme relates only to events reported from one of the buildings, the organisation uses this to compare reported rates with the other services internally. This process has not occurred since November 2014 and is raised as an area requiring improvement in criterion 1.2.4.3.There is a strategic management risk plan dated 2014-2016. The register identifies organisation risks, the risk rating, risk mitigation strategies, target risk rating, current risk rating, review timeframe and who is responsible. The risk register includes risks related to clinical care, human resources, finances, contracts, technology, data management, communication, natural disasters, occupational health and safety and marketing/reputation. There is an annual risk management report. The reports are sighted for the year ending 31 March 2013. The report for year ending March 2014 is currently being developed. The 31 March 2013 report includes the organisation’s philosophy of ‘best care’. Two staff are noted to have completed health and safety (H&S) level one training, one staff member completed H&S level two training and two staff members have completed H&S level three training. The risk register notes the minutes of the CQI meeting are placed on staff notice boards for all to read and sign. There is analysis of staff injuries and time off work. Overall policies and practices in place are reported to have resulted in reduction in time off work. Health and safety achievements are listed. Staff turnover rates are monitored and compared with industry. The RN resignation/change rate is reported to be well below industry norms. Evaluation of the results against the eleven H&S objectives set for the 12 months sighted demonstrates all except one objective has been achieved. One objective (minimising power wastage) remains a work in progress. The OD advises a new risk management report has been developed and will be implemented starting the end of April 2014. This will include managers and directors formally reporting against identified risks and key performance indicators on a monthly basis. The facility has maintained a workplace safety programme (tertiary level) as approved by the Accident Compensation Corporation (ACC). The organisation’s hazard register is sighted and this is current.ARRC contract requirements are met. |

##### 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:** PA Moderate |
| **Evidence:** |
| Stage one: The service have a reporting and investigation of serious incidents checklist and policy/procedure. This procedure implements the National Reportable Events Policy 2012, which purpose is to ensure systems are consumer centred, provide for early identification of incidents, ensure learning occurs to avoid repeated preventable adverse events, demonstrate accountability, transparency, and are safe. Open disclosure policy is sighted. Stage two: Staff interviewed, the CSM, and two charges nurses are able to describe their responsibilities in relation to the reporting of adverse events/incidents. A review of eleven resident files verifies appropriate events are being reported via the incident reporting process. While there is evidence of corrective action planning in relation to incidents, not all areas requiring improvement are being included. Incidents reported in Woodrow Grove are included in the benchmarking programme with some other services in Australia and New Zealand. While the CQI meeting includes an area for the number of incidents and type of events per building/service to be reported, only falls related data is in the table since November 2013. These are areas requiring improvement.There is a monthly falls prevention meeting where all residents who have had a fall in the month are discussed. The physiotherapist and CSM also attend this meeting and report active falls prevention strategies are discussed for each resident. Documentation related to this meeting is maintained.A policy document details the type of events which require essential notification. The OD is able to describe the events and who the notifications are to be made to. Template forms are available for use. Examples of essential notifications made include several related to the service being unable to provide RN staffing (as required to meet the Aged Related Residential Care Contract - ARRC) on occasional shifts. The rational is included in the notification form. An essential notification was also made via telephone in relation to the recent norovirus outbreak. |

##### 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:** PA Moderate |
| **Evidence:** |
| Twenty six staff interviewed, the CSM, and two charges nurses are able to describe their responsibilities in relation to the reporting of adverse events/incidents. There are two reporting forms in use. One reports staff related events and the other resident related events. A review of eleven resident files and staff related incident reports verifies appropriate events are being reported via the incident reporting process, including falls, skin tears, bruising, medication error, pressure area, absconding and episodes of challenging behaviour and staff injuries. While there is evidence of corrective action planning in relation to incidents, not all areas requiring improvement are being included. As an example one resident has four separate incident reports related to skin tears. Two of these reports identify the resident also demonstrated challenging behaviour. Whilst there are four separate wound care plans which demonstrate the skin tears are being actively managed, there is no evidence the challenging behaviour component has been evaluated and addressed. This is an area requiring improvement. Incidents reported in Woodrow Grove are included in the benchmarking programme with other services in Australia and New Zealand. The reports for the December 2013 quarter are sighted (refer to 1.2.3). Data is currently being collated for the next round of reporting. The CQI meeting includes an area for the number of incidents and type of events per building/service to be reported. The person responsible for incident report management has changed since December 2014. The minutes of the CQI meeting in February 2014 includes only falls related data in the table for each month since November 2013. This is an area requiring improvement. |
| **Finding:** |
| The staff are reporting incidents and accidents as required by the organisational policy. It is not always evident that all areas requiring improvement are identified and addressed. For example a resident has four incident reports for skin tears and two include episodes of challenging behaviour. Individual wound plans are developed for the skin tears, but there is no evidence that the challenging behaviour components have been actioned. There is a monthly form for the number and types of incidents per category, per building to be analysed. Since November 2013 the analysis data only relates to falls. |
| **Corrective Action:** |
| Ensure that all areas that are identified in response to an incident are actioned. Ensure the incident/accidents analysis includes all types of incidents reported.  |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Qualifications are validated prior to appointment as evidenced in the fourteen staff and manager files reviewed.Annual practising certificates (APCs) are obtained for the registered and enrolled nurses, the doctor, physiotherapist, dietitian and pharmacist. A register and copy of APCs, with expiry dates, is maintained. APCs are sighted for all staff and contracted service providers who require an APC. Certificates of prior learning are also obtained and kept where applicable in the staff files reviewed. The service have a training school that offers NZQA qualifications in residential care. Four staff are currently completing an industry approved qualification. Four staff have just graduated. The recruitment policy has clear guidelines for staff specifications to recruit the appropriately skilled staff (registered nurse, enrolled nurse and caregivers). Reference checks and interviews are conducted. A police check is also now undertaken on all staff. Five staff files reviewed were employed prior to the police checks being commenced. All staff receive an orientation programme. A half day (recently decreased from 8 hours) induction programme is undertaken and the programme includes introduction to key staff/managers and emergency procedures, infection prevention and control, health and safety and other important topics. Processes are implemented to ensure all new staff attend one of these days which are held monthly. Staff are also required to work through a check list during their orientation programme. They are buddied with a senior staff member for an agreed number of shifts. Copies of completed orientated records are sighted in eleven of fourteen staff and manager files reviewed. The two staff without orientation records have been in the facility for over 14 years and one staff member is currently still orientating. The orientation checklist is completed by ‘the buddy’ and staff member and signed off on completion by the clinical service manager or charge nurse. All staff interviewed confirm they are appropriately orientated to the organisation and their role and responsibilities. Annual performance appraisals are conducted. These are sighted in all relevant files except two. One of the overdue staff appraisals is sighted as in progress (halfway completed). The remaining appraisal was recorded within the staff database with an incorrect due date; therefore reminder processes had not been activated. A new staff database has been developed which identifies when staff APC, first aid certificates and annual appraisals are due. Auto reminders are emailed out to the relevant manager and process sighted.The education plans for 2013 and 2014 along with attendance records are sighted. Education provided in 2013 and 2014 year to date includes (but is not limited to): restraint minimisation, safe manual handling, wound management, continence, palliative care, the Code, fire, pain management, challenging behaviours, infection control, medicine management, care planning and assessments, spirituality and the role of the chaplain, grief, cultural safety, chemical safety, communication/documentation, and specific health conditions. Staff also attended an external first aid course (confirmed in eleven of fourteen staff files reviewed). Education is provided as part of the in-service education programme, training school or external specialists. The 26 staff interviewed report there an excellent range of education offered. All nine family/whānau and all fourteen residents interview report the residents receive a high quality of care. ARRC contract requirements are met. |

##### 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:** |
| Stage one: The service have a staffing calculator for both the rest home and hospital sections of the service. The staffing ratio policy is based on ARRC requirements and safe staffing guidelines.Stage two: The owner director (OD) develops the draft roster which is distributed to the charge nurses for finalisation. The qualifications and skill mix of staff are clearly identified on the roster utilising colours. There is always a registered nurse rostered on duty in Mountain View and Woodrow Grove. A caregiver in Mountain View attends as first responder to any calls by residents within the village. If there is only one RN on duty in the building the RN does not leave. Since the last audit a new system has been introduced where staff that are not rostered full time hours are allocated a ‘pick up’ shift on the roster. This person is called to work if there are unscheduled staff absences or if additional staff are required. All four staff and managers interviewed verify this system is working and reduces time spent contacting staff to fill shifts.The OD uses a spread sheet to identify the staffing numbers required per building. This is based on occupancy and the level of care required by each resident. A review of the current staffing requirements and roster verifies staffing is implemented per policy.The rosters sighted evidence the clinical services manager (RN) is on duty Monday to Friday morning shifts. There are adequate domestic, support and allied health staff to meet the needs of the residents. Three recreation staff shares the activities/recreation role.The care staff roster for Woodrow Grove (maximum 33 residents of mainly hospital level of care) confirm the following staffing levels: - there is a charge nurse rostered morning shifts- morning shift: there is often another RNs and/or at times one EN on duty along with seven caregivers (with staggered finishing times) - afternoon shift: one RN and five caregivers (with staggered finishing times) - night shift with: one RN and one caregiver. The rosters for Mountain View Apartments (maximum 45 residents with a mix of rest home and hospital level of care) confirm: - there is a charge nurse rostered week day mornings- morning shift: there is another RN and six or seven caregivers rostered on duty (staggered finish times). An enrolled nurse works some days.- afternoon shift there is one RN and four caregivers rostered (staggered finish times) - night shift there is one RN and two caregivers. One of these caregivers responds to calls in the Village when required.The rosters for Ocean View Apartments (maximum 12 residents with a mix of rest home and independent level of care) confirm: - a caregiver is on duty 24 hours per day. Twenty four hour staffing cover commenced in December 2013. The caregivers in this area work 12 hour shifts.All fourteen residents and all nine family/whānau members feel that all services are delivered in an appropriate and safe manner by well trained staff and that all their needs are met.There is always at least one (and often more) staff on duty in each building with a current first aid certificate as verified at audit.ARRC contract requirements are met. |

##### 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:** |
| Documentation in resident files sighted is legible, dated and signed by the staff member making the entry. Staff designation is also noted. Records are integrated with nursing staff, caregivers, the dietitian, physiotherapist, foot care nurse, recreation staff, and general practitioners documenting within the file. The GP can access information electronically from their practice as and when required.The resident files include copies of specialists’ letters, DHB discharge summaries, family communications, laboratory and other investigation results, consent forms, advanced directives, needs assessment and copies of enduring power of attorney/welfare guardian orders, where applicable.Records are stored securely. Records are archived in secure areas within each building for current resident and residents who have been receiving care within the past year. Beyond this time they are archived in another designated area. The CSM and CN interviewed advise overall records are kept for a minimum of ten years after the resident was provided care.An entry is made in resident progress notes at least each shift. |

##### 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:** |
| The service provides rest home and hospital level of care to the older and younger adult. The entry criteria is clearly identified and the admission process. There is an information pack available to potential residents and family/whanau on the services that are provided at Maida Vale. The service has a dedicated palliative care bed and has links with the local hospice and DHB to provide the end of life care. The referral agencies are provided with information on the services offered. Eldernet is updated daily with current occupancy and vacancy numbers. The clinical services manager reports there is a good working relationship with the local referral agencies that are aware of the service level offered at Maida Vale. ARRC requirement are met. |

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

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

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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:** |
| When entry to the service has been declined, the potential residents and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services. The clinical services manager interviewed reports that if a potential resident has an appropriate rest home or hospital level of care assessment and there is a bed available, the resident is not declined entry. The clinical services manager reports that they have not declined entry to a resident with the appropriate assessment. The admission agreement is based on the NZ Aged Care Association agreement. The agreement has a clause on the termination and changes of care. This includes ensuring that appropriate reassessment takes place to ensure that appropriate care is provided. The service does not provide secure dementia care, and if the service cannot safely maintain a resident with dementia at the service, the resident will be reassessed and an appropriate facility arranged in timely manner. The clinical services manager reports that the finding of a dementia level of care service can be almost immediate once the resident is reassessed; they report full support from the needs assessment agency in the timely manner that reassessments can occur. |

##### 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:** PA Low |
| **Evidence:** |
| During the review of randomly selected resident records, three hospital level, one hospital level person under 65 years and one rest home level care, it is clearly shown that all stages of service provision (assessment, planning, review, evaluation and exit) are undertaken by staff that are competent to do so. The sample size of files is increased by two to further review the follow-up and changes to care planning after adverse events. Health care assessments sighted are completed by a registered nurse, nutritional assessments are completed by a registered dietitian and resident manual handling needs are completed by a registered physiotherapist. As confirmed in documentation sighted and by staff, resident and family/whanau interviews, all care planning processes identify individual resident’s care needs and that appropriate actions are implemented to meet the needs. The use of appropriate assessment tools ensures a comprehensive assessment is completed for all residents within three weeks of admission.The organisation is transitioning to InterRAI electronic assessments and in Woodrow Grove there are ten resident files completed using the tool. One area identified for improvement relates to the timeliness of assessment reviews. Policy states this will occur at a minimum of six monthly. Three of the four care file reviews undertaken at Woodrow Grove identify that timeframes are not always met with assessments being undertaken from between seven and nine months apart.  Woodrow Grove: Tracer One. Tracer Methodology for Hospital Resident: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Woodrow Grove: Tracer Two. Tracer Methodology physical disability XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Mountain View: Tracer example three: rest home level of care resident.XXXXXX *This information has been deleted as it is specific to the health care of a resident.*The other four supplementary files reviewed (one hospital and three rest home) in Mount View and Ocean View apartments evidence that each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that meet the needs of the resident and contractual requirements with the DHB. The ARRC requirement of D16.3i is partially met. All other relevant ARRC requirements are met.  |

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

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

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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:** PA Low |
| **Evidence:** |
| Policy states that assessment is to be undertaken six monthly This does not always occur. Planning, provision of services and evaluation occur to meet timeframes and to meet resident needs. The service has a process in place to identify when each resident’s next assessment is due. This will be further enhanced by a centralised alert system which it being developed through a specific computerised system which the organisation hopes to implement fully within the next 12 months. |
| **Finding:** |
| Three of the four file reviews undertaken at Woodrow Grove show that the six monthly timeframes are not always met. The timeframes range between seven and nine months between re-assessments. Residents changing needs are shown on the care plan but not supported by appropriate assessment).  |
| **Corrective Action:** |
| Ensure assessment timeframes are met as per policy requirement and to support changes to care plans. |
| **Timeframe (days):** 180 *(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:** PA Low |
| **Evidence:** |
| Stage one: A suite of care service policy/procedures and assessment tools are sighted for continence management, challenging behaviours, pain management, personal grooming, personal hygiene, wound care, skin care, clinical managing, end of life care, death of a resident and falls prevention. These reflect current accepted good practice. Woodrow Grove: All six file reviews, five hospital and one rest home level care, identify the use of appropriate assessment tools. These cover all aspects of care and include falls risk assessment, skin integrity, Braden Scale for predicting pressure sore risk, mini nutritional, spiritual, cultural, continence/bowel, dietary needs and likes and dislikes, allergies, recreational needs, manual handling needs, Abbey pain scale, geriatric depression scale and mini mental as appropriate. Resident goals are developed and individualised to correspond to initial assessment findings.Nutritional assessments are completed by a registered dietitian and manual handling assessments are completed by a registered physiotherapist. Specialist needs identified are referred to the most appropriate person, such as the wound care nurse specialist, as appropriate. This ensures best practice nursing cares are implemented. Resident needs, outcomes and goals are clearly documented. However changes made to resident needs that are documented under the evaluation process are not always informed by appropriate re-assessment processes. This is an area identified for improvement.Mountain View and Ocean View: The five of five files reviewed (four rest home and one hospital) evidence the needs, outcomes, and/or goals of consumers are identified through the assessment process and are documented to serve as the basis for service delivery planning. When there is a change of needs, a reassessment is conducted and the long term care plan or short term care plan reflect the changes identified through the assessment process. The ARRC 16.2c is partially met with the other ARRC requirements of D16.2 are met.  |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Changes are identified on the residents’ care plans to keep residents safe. Specialist input is sought as appropriate to inform best practice nursing interventions. However not all residents’ changing needs are identified via the assessment process. (Refer comments in criterion 1.3.3.3). This was discussed on the day of audit with the CN/RN and the clinical service manager. The hospital level care resident review undertaken had incongruent information related to mobility between what was shown in the evaluation part of the care plan and what was stated on the assessment form. The rest home care resident’s file identified that the resident was at high risk of developing pressure areas but no updated assessment informed this. The assessment sighted stated low risk of pressure areas. The resident notes identified they presented with behavioural issues and whilst management interventions are identified on the care plan on how to manage the behaviour there is no assessment to inform the decisions shown. One resident had a moderate falls risk assessment but the interventions shown stated high risk. |
| **Finding:** |
| Initial assessments identify all resident needs. However not all ongoing needs or changing needs are informed by the assessment process. Changes are made to the care plans to reflect residents’ changing needs but they are not informed by the assessment process. Examples sighted relate to behaviour management, mobility, falls risk ratings and skin integrity. |
| **Corrective Action:** |
| Ensure changes to interventions are informed by use of appropriate assessment tools. |
| **Timeframe (days):** 180 *(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:** |
| Care plans are resident focused, integrated and promote safe continuity of care. In all 11 of 11 files reviewed (six hospital and five rest home) from across the service, interventions relate to the residents’ outcomes which are individualised. The care plans reflect clear interventions and the support required to achieve the desired outcomes. In three of residents’ files reviewed in Woodrow Grove, not all interventions have clear assessment guidelines refer to comments in criteria 1.3.3.3 and 1.3.4.2.Care plans are completed by registered staff and are accessible to all staff. All 11 of 11 files included nursing notes that are updated each shift, medical reviews which are very clear and give ongoing instructions to staff and contain hospital and other correspondence associated with resident care. The care plans are written in easy to understand language. MDT meeting outcomes inform the resident’s care plan and findings are congruent with actions sighted on care planning interventions with resident and family/whanau input clearly identified. All health professionals document in the resident's individual clinical file and have access to care plans and progress notes.Interviews with staff (11 caregivers, two enrolled nurses, three registered nurses, the recreational officer, the physiotherapist, the restraint coordinator and the infection control coordinator) confirm they report all concerns and that they have undertaken appropriate education related to use of correct terminology when writing in resident notes. They confirm care plans are easy to understand and guide their everyday interventions with residents.The 14 of 14 resident interviews (seven rest home and seven hospital level care, including one younger person) and nine of nine family/whanau interviews confirm that they are kept well informed and feel involved in care decisions. Family/whanau is always informed if staff have any concerns. ARRC requirements are met. |

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

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

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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:** |
| A review of six hospital and five rest home level care resident files, identify that residents receive adequate and appropriate services to meet all their needs and to support them to reach identified outcomes. The interventions documented ensure all residents’ needs are addressed. This is confirmed during interview with 14 of 14 resident interviews (seven rest home and seven hospital level care, including one younger person), and nine of nine family/whanau interviews. Very supportive comments related to care services and how supportive management are were made to all three auditors during interviews with residents and family/whanau.Interviews with staff (11 caregivers, two enrolled nurses, three registered nurses, the recreational officer, the physiotherapist, the restraint coordinator and the infection control coordinator) and the GP confirm there is excellent communication between all disciplines to ensure all resident needs are catered for in the best possible manner. Evidence of sharing of information is supported during the attendance of Woodrow Grove handover between shifts. Each staff member has a written handover sheet which describes resident care needs, concerns or issues that may have arisen. Caregivers report that they have input in to care planning decisions as appropriate and that registered staff are always responsive to any concerns they have related to residents’ changing needs.Resident files contain referrals to appropriate services which include mental health, outpatient clinics such as ophthalmology, hearing and specialist areas as required for example urology and surgical services. The service employs a dietitian and a physiotherapist on a part time basis to ensure all new residents have appropriate assessments upon admission and regular reviews are performed by both these disciplines. Input is included in the annual MDT meetings held for each resident. Referrals to community groups also sighted for residents who wish to attend off site groups or clubs.Staff report that there are adequate continence and dressing supplies available. Supplies sighted confirm this. ARRC requirements are met. |

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

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

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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:** |
| Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. There is variety of planned activities for the different levels of care in the services (eg, the older and younger adult, dependence levels and gender). The nine of nine resident files reviewed evidence an assessment and plan for planned activities. A monthly planner is developed by the recreation officer for each wing and includes activities identified and/or requested by residents (plan sighted). The planned activities meet the recreational, social, physical and emotional needs of the residents. There are group and one to one planned activities. There is a chaplain that provides non-denominational spiritual and emotional support to residents on a one to one basis and group church services are conducted at the facility two weekly. Residents may also go out with their family/whanau to church services. At the time of audit there are five residents under the age of 65 years. There is a three monthly resident meeting of the younger residents, where input into activities is gained. The recreational officer interview reports specific aged appropriate activities are organised, such as going to MacDonald’s. Some of the younger residents have the same medical diagnosis and have additional support from that group for planned activities. There are three different resident meetings being held. In Mountain View these meetings are held monthly and in Woodrow two monthly. Minutes of three meetings sighted includes discussion on the activities programme and ideas for new or different activities. The recreation officer advises residents are reluctant to have too many changes in the programme. Records of resident participation in the activity programme are maintained and sighted in nine of nine residents’ files reviewed at audit.The 13 of 14 residents and nine of nine family/whanau interviewed confirm that there are a variety of appropriate activities available to meet their needs. The younger person interviewed report that they prefer not to participate in the planned activities at the service. The ARRC requirements are met.  |

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

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

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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 evaluation process is well documented and shows that care is resident focused. The degree of achievement or response to interventions put in place is used to measure the progress residents have made toward achieving their stated goals. Evaluations are undertaken at least six monthly or as required to reflect residents changing needs. Documentation sighted in 11 of 11 resident files reviewed from across the service (six hospital and five rest home), interviews with 14 of 14 residents and nine of nine family/whanau members confirm they are kept well informed of changes to interventions or any concerns the staff may have related to their relative.In the 11 of 11 files reviewed at Woodrow Grove, Ocean View and Mountain View, the evaluation process was updated more frequently than six monthly in response to residents changing needs to ensure the best possible outcome could be achieved. For example, the hospital resident reviewed had changes made to PEG feeding requirements and weight management. The rest home care resident had changes made to reflect ongoing behavioural problems. Short term care plans are used for issues that can be resolved quickly, such as the use of antibiotics for infection. Wound care management is clearly shown and evaluated on the resident’s care plan.. (As noted in criteria 1.3.3.3 and 1.3.4.2 evaluation updates are not always informed by assessment processes).ARRC requirements are met. |

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

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

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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:** |
| Referrals to other providers evident in 11 of 11 file reviews from across the service (six hospital and five rest home) are mostly for ongoing specialist assessments. Transport is provided for residents to attend external appointments in the community as required. The service has a very good relationship with the geriatricians at Taranaki Base Hospital and with the local needs assessment agency. Residents are referred for reassessment if the service cannot meet their needs. This is confirmed during interviews with management. Regular meetings are held with the portfolio manager from Taranaki District Health Board who attended a meeting with management during the time of audit. Family/whanau are always notified of any referrals prior to them being sent as confirmed during nine of nine interviews. Referral processes are documented and in place to guide staff to ensure residents’ needs are met. Referrals are appropriately facilitated by the GP or CN/RN as demonstrated in the referral related to and the due date not being met by the speech language therapist. A referral to a dietitian, and it is documented that the resident declined a referral to the ulcer clinic. Email documentation is sighted reminding the speech language therapist from the hospital that the visit was overdue. Residents have the option to use their own GP or to use the GP contracted to provide services at Maida Vale. Resident choices are respected as confirmed during resident interviews.ARRC requirements are met.  |

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

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

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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:** |
| Exit and discharge or transfer processes are clearly described in policy. These are implemented throughout the facility. All relevant information accompanies the resident, including any known areas of risk such as high falls or behavioural issues. Woodrow Grove, Mountain View and Ocean View: Documented processes are followed for all discharge or transfers carried out. The specific form used is uniformly used throughout the Taranaki region and is approved by the DHB. The form identifies all known risks and includes any concerns expressed by family/whanau. Medications sent with residents if they are transferring to the hospital are sent in the ‘green’ bag to avoid loss or confusion about the resident’s current medications being taken. One resident discharged home from Woodrow Grove had all home based service put in place by the local assessment agency. This is common practice in Taranaki. The GP sent all necessary medical information to the resident’s nominated GP and the resident’s current care plan was provided to the home based service that were to undertake ongoing support. |

##### 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:** FA |
| **Evidence:** |
| Stage one: The sighted pharmacy manual shows safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. There is an assessment and consent process for residents who are able to self-administer their medicines. Stage two: The service implements the medicine management process according to the policy and procedures. A safe medicine management system is observed at the time of audit (observed a RN administering the medicines in Woodrow Grove, an EN observed in Mountain View and a caregiver in Ocean View Apartments). Only RNs administer medicines at Woodrow Grove.The medicines are dispensed by the pharmacy in the Medico Paks. The Medico Paks are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines and inhalers) are individually supplied for each resident. The Medico Paks are checked for accuracy against the prescription by the RN when they are administered. The GP conducts medicine reconciliation on admission to the service and if the resident has been to the acute care hospital or seen by a specialist. The GP conducts a review of the resident’s medicines at a minimum of three monthly which is signed for on the resident’s medication chart. The service does not use standing orders; all medicines are individually prescribed for each resident. All medicines and the medicine trolley are stored in the locked medication rooms in each of the different services. The medicines fridges are monitored for temperature daily. Controlled drugs are stored in a safe in the medication room and are signed out by two staff when given. A weekly stock count is recorded in the controlled drug register. The pharmacist conducts a six monthly stock count of the controlled drugs; this is last conducted in March 2014. A review of 18 of 18 medicine charts identifies that each medication is signed for by the GP. The prescriptions are legible, record the name, does, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify resident allergies and have a current photograph of the resident for identification purposes. Sample signature verification is recorded for all staff who administers medicines.All staff who management medicine have a current mediation competency for the role. The staff interviewed report that the competency is conducted annually. The medicine competency involves a written test and practical observation. Some caregivers have competency for the checking of controlled drugs. The RNs in the hospital facility (Woodrow Grove) have competency assessments for the use of subcutaneous infusions. A register is maintained of the staff members competent to perform the different roles. There are no residents at the time of audit who self-administer there medicines. ARRC requirements are met. |

##### 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:** 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 1.3.12.3 (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 service has a six weekly rotating menu which is approved by a qualified dietician (the last review was September 2013). Initial assessment of residents' includes a dietary assessment and a copy of this is sent to the kitchen. A dietitaian condcuts the intial nutirtional assessments, and is invloved with any changes with the residents nutritional needs. The resident reviewed has dietitian input for wound care. Four of four file reviews in Woodrow Grove (three hospital level care for hospital and one for a resident under 65 years) contain detailed nutritional assessments undertaken by a registered dietitian to ensure all needs are met. A large white board in the kitchen also documents up to date specific dietary requirements. Food allergies are also highlighted as part of this process. The service have a food safety management systems certificate dated January 2014 to December 2014. Food deliveries are stored appropriately in the pantry, chiller, fridge and freezer. Food in the fridge is stored appropriately which includes covers and dates. The catering manager reports that they try to keep all foods in their original packaging and if decanted, food is dated and labelled. There is a separate cleaning schedule for the kitchen and documentation was available to provide evidence that the cleaning is completed as per the schedule. The range hood and vents are cleaned regularly by an external contractor and were clean on the day of the audit. There is a fire blanket and fire extinguisher located in the kitchen and appropriate hand washing facilities. The cook is responsible for daily recording of the temperature of the fridge, freezer and chiller as well as meat temperatures. Temperature recordings sighted are within the recommended guidelines.The 14 of 14 residents and nine of nine family/whanau interviewed confirm that most meals are provided at an appropriate temperature and that there is a sufficient amount of food provided. Some residents did provide some feedback that they felt that the lighter evening meals was not as good as the morning and midday meal. The ARRC requirements for hospital and rest home level of care are met. |

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

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

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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:** |
| Stage one: Policies are sighted for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.Stage two: Chemicals are supplied by an approved supplier who ensures safety data sheets are kept up to date as sighted on the days of audit. Chemical storage areas are well labelled and secured. All chemicals, including those decanted, are correctly labelled.As confirmed by the maintenance/grounds manager there are no specific territorial authority requirements for waste disposal. Maida Vale undertakes appropriate storage and disposal of waste, infectious and/or hazardous substance to comply with current legislation. The service has undertaken a project related to improving where waste is collected from. This has resulted in a new area being developed at the entrance to the facility grounds where the large waste management bin is kept for ease of collection. There is a regular daily pick up programme for all types of waste care bins around the site. A modified vehicle is used and bins are emptied into the large waste care bin in the newly developed area. Staff and management report this is working very well. Waste type is determined by the colour of bin it is placed in. Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons, goggles and masks. Interviews with 26 of 26 staff from across the organisation confirm they can access PPE at any time and they can verbalise appropriate use. This includes maintenance and gardening staff. Clinical staff are observed wearing disposal gloves as required. Approved yellow sharp bins sighted are used for the safe disposal of sharps. Sharps bins are located in all the medication rooms.ARRC requirements are met. |

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

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

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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:** |
| Documentation sighted identifies that all processes are undertaken as required to maintain the service building warrant of fitness. Three buildings have individual warrant of fitness certificates. They are all current. Mountain View and Ocean View are dated 13 March 2014 and Woodrow Grove dated 14 March 2014. Regular and long term maintenance schedules and plans are well documented. The members of the maintenance team ensure that reactive maintenance is undertaken promptly as evidenced in work sheets sighted. All requested maintenance jobs are signed off upon completion and timeframes are monitored and overseen by the maintenance/grounds manager. Electrical testing occurs throughout the year and all electrical appliances are tested prior to use at the facility. This includes new equipment and resident equipment. One member of the maintenance team is approved to undertake the test and tag electrical safety testing to meet AS/NZS 370-2010 A1 and A2. This qualification (E258111) is available in the staff member’s file. There is a system in place to identify when electrical equipment is due to be retested. All equipment over the value of $500 is bar coded and allows the organisation to maintain an up to date asset register. The electronic data base is sighted.Biomedical and medical equipment which includes beds, hoists, otoscope, oxygen connectors and regulators, sphygmomanometers, stethoscopes, syringe drivers and chair scales had safety checks and were calibrated by an approved provider in December 2013. Items which fail the test and calibration are removed and either repaired or replaced. A list of when calibration dates are due is kept in the office and monitored to ensure this process is undertaken to meet best practice requirements.The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas are kept clutter free. All wheelchairs are numbered and a regular cleaning regime is in place. Wide corridors with safety handrails assist residents to mobilise safely. Residents who have mobility difficulties are assessed by a physiotherapist and appropriate walking aids are obtained to assist with safe mobilisation. This is clearly demonstrated in the files of the residents.The service has installed one ceiling hoists and intends to install up to five per year in hospital level bedrooms. This is an ongoing quality improvement project. The company who install the ceiling hoists is contracted to ensure all compliance testing is maintained. Six monthly environmental audits are undertaken and corrective actions are documented for areas that have a deficit identified. The maintenance book and interviews with staff (including the maintenance staff) and residents confirm repairs are undertaken as soon as possible. Monthly maintenance checklists sighted are up to date. Residents have access to well-maintained outdoor areas with seating and shaded areas. Interviews with 14 of 14 residents (seven rest home and seven hospital, which include one younger person) and nine of nine family/whanau members confirm the environment is suitable to meet their needs. Residents were observed walking around inside and outside the facility both independently and with the use of walking aids.ARRC requirements are met. |

##### 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 areas have adequate numbers of accessible toilets/showers and bathing areas. Woodrow Grove has either single ensuites or an ensuite shared by two rooms. Other areas have shared facilities for no more than five rooms. Every bedroom has hand washing facilities. Sanitising hand get is available throughout the facility.There are separate staff and visitor toilets throughout the facility.Hot water temperatures are monitored and recorded and if this goes over the required 45oC in a resident area it is regulated and rechecked. This process is undertaken by the maintenance team who record all actions. Documentation sighted shows that all water temperatures have been maintained since the previous audit. ARRC requirements are met. |

##### 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:** |
| Most resident bedrooms are single occupancy. There is one bedroom shared by two non-related residents with family/whanau consent. There are some double rooms available for husband and wife teams. Currently only one is occupied by a couple; the other rooms are single occupancy. All bedrooms are personalised to meet residents' wants and needs and are large enough to enough to allow residents with or without mobility aids to move around safety. The residents under the age of 65, is delighted with the bedroom they occupy as it is large enough to live very comfortably even with all the mobility equipment required to allow the residents to maintain independence. Interviews with all other residents and family/whanau confirm they are happy with their bedrooms and that they can personalise the area. ARRC requirements are met |

##### 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:** |
| The physical environment provides safe, age appropriate and accessible areas to meet residents’ needs. This is confirmed during resident and family/whanau interviews which identified that they are all very happy with the facilities provided. Each building has appropriate dining, lounge and entertainment areas. Areas are furnished to a good standard. ARRC requirements are met. |

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

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

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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:** |
| Stage one: Policies sighted for the cleaning, laundry and the safe and hygienic storage of cleaning/laundry equipment and chemicals, comply with requirements of the standard. Stage two: There are laundries located in the Woodrow Grove and Mountain View services. Both of these services had an external audit against the code of practice for laundry operations services in January 2014 and gained a six months compliance certificate for this. The laundries in both Woodrow Grove and Mountain view have a dirty to clean flow. There is monthly monitoring of the methods, frequency, and materials used for laundry processes by the external chemical supplier. The results are reported at the monthly CQI meeting. The laundry and cleaning staff have access to designated areas for the safe and hygienic storage of cleaning and laundry equipment in both the cleaning, laundry and sluice rooms in Woodrow Grove and Mountain View. The chemicals are securely stored in the areas sighted. The 14 of 14 residents interview report satisfaction with the cleaning and laundry services. The ARRC requirements are met.  |

##### 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:** |
| Each of the three major buildings has an evacuation plan that has been signed off by the New Zealand Fire Service. Ocean View and Mountain View plans were approved on 18 April 2002 and Woodrow Grove is dated 18 March 2006. Six monthly trial fire evacuations are conducted in conjunction with the local fire service. The last trial evacuation occurred on 05 November 2013 and no recommendations were noted. Staff education records identify attendance at trial evacuations and fire training. This is an annual compulsory attendance and is closely monitored by management. Fire and emergency training is included in staff orientation and regular on-going sessions are undertaken throughout the year. The emergency manual is reviewed annually and this last occurred in March 2014. Documentation identifies staff roles and responsibilities should an emergency occur. This covers clinical, domestic, property and fire warden responsibilities.Fire equipment was checked by an approved provider in February 2014. Records identify that all checks for sprinkler, fire doors, emergency lighting and signage occur to meet all building warrant of fitness requirements. The sprinklers are connected to the fire service. Smoke detectors are battery operated and these are checked at least annually. There are manual fire alarm points throughout the facilities. Civil defence and emergency supplies are centrally located and checked six monthly. The service ensures there is emergency food and water for a minimum of three days. Food is rotated to ensure it is used within best before dates. The emergency water tank (10,000 litre tank) supplies one room with water to ensure there is daily use of the water which is automatically replaced. The service has a petrol operated emergency generator in case of an emergency. There is a well-stocked pandemic cupboard. The facilities pandemic plan was updated in April 2014. There are first aid kits in all vehicles, at each nurses’ station and in non-clinical areas. The service gained tertiary level ACC in June 2013 for the Workplace Safety Management Programme (WSMP).Staff rosters identify that there is always a staff member on duty who holds a current first aid certificate. All shifts are covered by registered nurses (RNs). Staff are required to ensure doors and windows are securely closed at night. There is an approved security company who undertakes three nightly random checks of all buildings and the grounds. There is CCTV around the grounds and within the buildings (67 cameras) which can be monitored as required. Call bells are located in all resident areas. A recent quality improvement has been undertaken which allows call bell response time to be monitored - documentation sighted. Interviews with 14 of 14 residents and nine of nine family/whanau members confirm staff respond quickly when the call bell is activated.The latest QPS benchmarking results for environment gained above 85% satisfaction from residents and family/whanau.The service has undertaken a two and a half year project related to the use of resident locators for residents who wander and have developed an electronic system ‘Avatar Trakakiwi’ which allows residents maximum independence around the site without being at risk of wandering off the grounds. Having met the required standard this project has gained a continued improvement rating related to safety and security of residents. |

##### 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:** |
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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 1.4.7.3 (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:** CI |
| **Evidence:** |
| The service has night patrols which check the grounds and buildings three times a night at random times. There are CCTV cameras which can be monitored as required. The service has undertaken a two and a half year project to find an electronic warning system to identify when residents with short term memory loss, who wander can move around the facilities and grounds independently without being at risk of wandering onto the road. |
| **Finding:** |
| The Avatar Trakakiwi security system has been developed via use of iPhone technology and has set safe parameters that residents can move around in. If the resident goes to the edge of the perimeter and is at risk of exiting the grounds an alarm alert is triggered on the units carried by staff and they are informed where the resident is. They can then guide them back to the areas within safe limits. This project has been closely monitored and involved staff from all areas. Evaluation identifies there have been no incidents of residents who ‘wander’ leaving the grounds since its inception. |
| **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 resident areas have adequate natural light, safe ventilation and are appropriately heated throughout the year. The ceiling central heating system is well maintained. Ventilation is maintained by the opening of doors and windows. This is confirmed during resident and family/whanau interviews and observation on the days of audit. |

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

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

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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:** CI |
| **Evidence:** |
| Stage one: The restraint minimisation manual is sighted. The service has adequate policies and procedures. The Policy at Maida Vale is that restraint is used as a last resort only and only used where safety is compromised. Restraints approved for use at Maida Vale are bedrails, lap belts, chair vests and mittens. Enablers are defined as the voluntary use of equipment by a resident to assist them in maintaining independence. Stage two: For the restraint minimisation standards the restraint coordinator and five caregivers are interviewed. Two files of residents requiring restraint use are reviewed. The restraint coordinator repots the service is actively minimising restraint; this is achieved through the use of alternative equipment to limit the use of restraint. There are eight residents in March 2014 that require the use of restraint. This is reduced to six residents in April 2013. The service has completed projects and quality activities, which are analysed and evaluated to ensure the safe and appropriate use and minimisation if restraint use where possible. Refer to the criteria 2.1.1.4 for the continuous improvement rating. The current approved restraint in use at the time of audit are bed rails, lap belt and chair vest. There are two residents who, at the time of audit are assessed for enabler use. There is one resident using bed rails as enablers and another with a lap belt or harness when they are in their electric wheelchair. The enabler use is sighted in the restraint register and confirmed at interview with the restraint coordinator (RN). As sighted in the services policy if enablers are to be used, they shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety. Training records show education provided on restraint minimisation and safe use and management of challenging behaviours in 2013.The organisations has competency for restraint minimisation and safe use for the care staff, and this is sighted in the care staff files reviewed. The 16 of 16 direct care staff interviewed demonstrate knowledge on restraint and enabler use and the minimisation of challenging behaviours.  |

##### 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:** CI |
| **Evidence:** |
| The organisation demonstrates that the use of restraint is actively minimised. The service has completed a three year analysis of restraint use from July 2010 to June 2013. The analysis records that the service is actively reducing the use of restraint. The number of residents requiring restraint use in November and December 2010 was 20; this has reduced to 10 in June 2013. The current number of residents requiring restraint use is six (April 2014). The results of the surveys are addressed to the staff in-service and communicated to staff. This is having a positive outcome for impacting on resident safety and satisfaction by minimising the use of restraint. The restraint coordinator also reports that with the minimisation of restraint use and the use of other restrained alternatives is not impacting on resident falls. Other quality activities are conducted for the safe and appropriate use of restraint, enabler use and the associated monitoring processes of restraint use. These projects identify the objectives and plan to addresses the issues related to the ongoing monitoring of restraint use. The analysis of the projects indicates that the service is achieving their documented goals. |
| **Finding:** |
| The organisation’s achievement for actively minimisations of restraint use is beyond the expected full attainment. The organisation has conducted a number of projects and quality reviews of the restraint minimisation and safe use practices, which include analysis and reporting of findings. There is documented evidence of action taken based on findings and improvement to service provision and the safe and appropriate minimisation of restraint use. The residents’ safety has been measured as a result of the review process, which indicates there has been no falls as a result of the removal of the restraints.  |
| **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 approved restraints at the service are bedrails, lap belts, chair vests and mittens. At the time of audit there are six residents assessed as requiring restraint use of bed rails, lap belt or chair vest. The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. The restraint coordinator approves all restraint use, in conjunction with the restraint approval group. The review of restraint use is part of the monthly restraint approval group and a formal quality review of the restraint use is conducted six monthly (March and September). The care plan records the restraint required, when it is to be applied and monitoring requirements, as confirmed in two of two residents’ files. The five of five care staff interviewed confirm their knowledge of the restraint approval process which they fully implement. Once a restraint is approved it is documented in the care plan. Consent from family/whanau, GP and RN is required before restraint is approved. |

##### 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:** FA |
| **Evidence:** |
| The restraint coordinator reports that restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by including all the requirements of the standard. Assessment considers risk and benefits of restraint or enabler use, such as will it compromise the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm and is there a balance between independence and protection. The two of two residents’ files reviewed of residents assessed as requiring restraint identifies that assessments are formally reviewed six monthly, with all restraints reviewed at the monthly restraint approval group meeting (the review can be conducted sooner if the residents needs change). The 11 of 11 care assistance interviewed demonstrate, understand and implement alternatives to restraint, such as low beds, sensor mats, pull string alarm and antiroll mattresses whenever possible. The ARRC requirement is met. |

##### 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:** 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 2.2.3: 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:** |
| The restraint coordinator reports that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained. At the time of audit, six residents require the use of restraint to maintain safety of the resident. Restraint planning is undertaken only if the assessment process indicates the use of restraint would be appropriate. Frequent falls by individual residents will often generate commencement of assessment processes and all alternative methods of keeping the resident safe are identified (confirmed in the two of two resident files reviewed). Restraint is documented in the resident's file and in the restraint register (sighted). The restraint register records the date of authorisations, type of approved restraint, reason for use, behaviour assessment, review dates, if the monitoring of restraint complies with policies, if the care plan reflects the restraint use, if guideline are being completed with and the date of discontinuation. The ARRC requirement is met. |

##### 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:** |
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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 2.2.4: 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 restraint coordinator reports that that all restraint is formally evaluated six monthly as part of the resident quality review process and this is confirmed in the two of two residents’ files reviewed. There is more informal evaluation daily through the monitoring forms, and through the monthly restraint approval group. The six monthly evaluation processes includes family/whanau and resident input as appropriate. Restraint reviews are reported and discussed at the quality meetings and types of restraints in use are monitored by the quality committee. Documented six monthly reviews sighted in the two of two residents’ files identify that assessments are updated as part of the review process to evidence the need for continued restraint or recommendations are made to cease restraint. Interviews with five of five care staff confirm they have input into restraint evaluation processes. The ARRC requirement is met. |

##### 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:** |
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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 2.2.4.2 (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:** |
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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 2.2.5: 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 monitoring form includes the type of restraint, reason for use, time frames for monitoring, how long the restraint is to remain in use and a record of the checking of the resident. The file review of one resident’s monitoring form indicates two hourly monitoring of the resident when the bed rail is up. The quality review of restraint is part of the quality meeting and there is a specific six monthly review of restraint use at the service. The six monthly review of restraint (this is done in March and September each year) includes the types of restraint used, the alternatives, if the restraint is used for the least restrictive and minimum amount of time, if policies and procedures are followed, impact of restraint, if the care plan provides information on the restraint use, if the consent forms and evaluation include family/whanau involvement, if staff education is required, review of the restraint registrar and any corrective actions that are required. The restraint coordinator reports that they have been able to reduce and cease the use of restraint in a number of cases. All restraints are used for the safety and comfort of the resident. The restraint approval group meeting minutes (sighted for 2013 and to date in 2014) record that the there is an active minimisation of the times that restraint is used, the example is given that the chair vest harness is released for residents when they are seated in highly visible and high staffing areas. The ARRC requirements are met.  |

##### 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:** |
| Stage one: The infection control manual sighted reflects current accepted good practice. The organisation demonstrate their commitment to the Infection Control Programme through the eight identified objectives below: - All reasonable steps will be taken to ensure that every resident at Maida Vale is nursed in accordance to aseptic techniques.- A developed, implemented and maintained effective facility wide Infection Control Programme is in place and reviewed annually.- There are written policies and procedures for ongoing audit and evaluation of our facility wide Infection Control Programme, which are reviewed by the quality and risk personal 2 yearly or if changes are required.- That all staff are educated in the principles and practices of infection prevention and control, and ensures copies of policy and procedures are made available to all staff.- That the infection control officers have input into proposed building construction and new equipment to ensure accepted infection control requirements are met.- That invasive procedures are minimal to reduce infection rates. - That the infection control programme provides information that assists the organisation to be able to extrapolate information that assists and ensures that risks are identified and the degree is rated which is appropriate to the size and scope of the business.- That the Infection Control Programme will call on the expertise of the risk advisor / assistant manager from Taranaki District Health Board, the General Practitioner visiting the facility, laboratory service and any associated information from the GP request from a microbiologist as well as their own appointed RN responsible for Infection Control in both our facilities.Stage two: The above objectives are sighted as implemented at the onsite audit. 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. There are two infection control officers for each of the buildings at Maia Vale; they have job descriptions that outline the scope of the role and the accountabilities for the role. The infection control officers are allocated four hours per month each to achieve the infection control role and organisational objective. The infection control data, statistics and analysis are reported though the CQI meeting. The senior management are part of the CQI committee. Immediate issues (eg, outbreaks) are reported to senior management immediately. The infection officer interviewed reports that there is good support from the senior management in achieving the organisational goals related to infection prevention and control. The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. The infection prevention and control programme is last conducted in March 2014. There is an annual analysis of the infection control surveillance programme; this report includes the objectives, results and conclusion of the data from April 2013 to March 2014. Service providers and/or resident and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious. There are staff policies that advise the staff not to come to work if they are unwell, and the preclusion from work times before the staff member can return to work. There are notices at each of the entrances to advise people not to come into visits if they have been exposed to an infection or are feeling unwell. The ARRC requirements are met.  |

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

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

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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 officers have access to a consultant with a range of skills, expertise and resources through the DHB who is a specialist in infection control. The consultant is part of the three monthly risk management committee at the organisation. The infection control officer interview confirms that the service also has access to external advice through the GP, product supplier, specialist infection control contractors, DHB and Ministry of Health services as required. The infection prevention and control officers meet monthly as part of the CQI committee to monitor infection rates and to put corrective actions in place as required. Members of the committee report they have adequate human, physical and information resources to implement the infection control programme. The infection control officers have allocated time each month for the infection control role. The ARRC requirements are met.  |

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

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

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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:** |
| Stage one: The Infection Control Manual is reviewed by an infection control advisor from the DHB and that person must ensure all references used in the manual are correct and are congruent with best practice. Stage two: There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. The infection control manual is last reviewed against best practice in February 2014.The ARRC requirements are met.   |

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

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

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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:** |
| There are two in-service education sessions conducted a year as part of the ongoing education programme. The infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. These two in-services are conducted by infection prevention and control specialist from the DHB. The education is conducted on topical and local issues related to infection prevention and control. Other education on infection prevention and control is conducted by the infection control officers. The infection control officer interviewed demonstrates knowledge on current practice and is a member of the infection prevention and control nurses college. The infection control officers conduct informal education at handover as a result of observation of work practices, and if there is an indication from internal audits or the infection control surveillance (eg, effective hand washing). When the service had an outbreak in April 2014, additional education is providing on the transmission based precautions and the care of the residents. Infection prevention and control education is part of the staff orientation and the annual knowledge booklet. Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control officer reports that resident education is done informally, for example when a resident has reoccurring urinary tract infections (UTI, hand hygiene, perennial care and the importance of adequate fluid intake is discussed with the resident. The infection control officer has developed a brochure for residents and family regarding outbreaks of viral gastroenteritis. This brochure is developed as an outcome of the recent Norovirus outbreak and provides advice and support information for the resident, family and whanau on outbreak management. The ARRC requirements are met.  |

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

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

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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 organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. Staff are responsible for completing an infection reporting form for all residents who are suspected or diagnosed as having an infection. The infection control officers review all residents' forms to ensure residents meet the criteria. Infections are summarised on a monthly basis and reported per category of infection and per wing. The type of infections are categorised as new or existing or present on admission. Infection rates are reported at the CQI and risk management meetings. A representative from the DHB is involved with evaluating infection surveillance data submitted. The infection control officer advises infection rates are benchmarked with the Quality Performance Systems (QPS) for the Woodrow Grove service and internally collated and benchmarked for the Mount View and Ocean Grove services. The QPS report sighted the second quarter for December 2013 record that the service is under the acceptable average for infections. The benchmarking data is also displayed for staff on the ‘red hot’ notice board. The service has since (April 2014) had a Norovirus outbreak which was contained to six residents in Woodrow Grove. The infection surveillance data analysis records an increase in urinary tract infections (UTIs) in the rest home for the months of May, June, August 2013 and January 2014. The analysis records that this is due to the residents being less accepting of fluids, independently toileting themselves with less suitable hygiene practices. The UTIs in the hospital sections are record as significantly less than what is recorded in the rest home for the same period. The analyses records correct hygiene procedures by staff as being a contributing factor with the reduced UTIs in the hospital section.  |

##### 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:** |
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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.)* |

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

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

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