# Taumarunui Community Kokiri Enterprises Limited

## Current Status: 10 April 2013

**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

Te Arahina O Arihia Rest Home is a 25 bed aged care facility providing rest home and dementia level care. Occupancy on the day of the audit was at 18. The facility is operated by Taumaruni Community Kokiri Trust. Staff hours are increased if required to meet the needs of residents.

Residents and family interviewed were very positive about the care provided and staff being very supportive. There have been no changes in the facility, staffing structure, management or systems since the last audit.

One area has been rated as continuous improvement (beyond the standard normally expected) relating to a quality iniatitive implemented to reduce the rate of urinary tract infections in the facility. There are no areas identified as requiring improvement during this audit.

## Audit Summary as at 10 April 2013

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 10 April 2013

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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 10 April 2013

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

### Continuum of Service Delivery as at 10 April 2013

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

### Safe and Appropriate Environment as at 10 April 2013

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

### Restraint Minimisation and Safe Practice as at 10 April 2013

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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. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 10 April 2013

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

## Audit Results as at 10 April 2013

### Consumer Rights

Support provided at Te Arahina O Arihia Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected.

Te Arahina O Arihia Rest Home supports residents who identify as Maori and have appropriate policies, procedures and community connections to ensure culturally appropriate support is available.

Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents and family/whanau are kept informed.

Access to advocacy services is available through the local community support agencies. Te Arahina O Arihia Rest Home encourages residents to maintain connections with family/whanau and their community.

The manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' monthly meetings. Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.

### Organisational Management

The purpose, values, scope, direction and goals of the organisation are displayed and reflect the services provided. Day to day operations are the responsibility of the manager who is a registered nurse (RN) and who has appropriate skills and experience. The manager is supported by a registered nurse who assists with oversight of clinical care. Registered nurse cover is provided six days a week.

The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated during regular staff meetings and manager reports. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and managed.

Human resources management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hour period with experienced advice and assistance available. Sufficient orientation/induction is in place for staff. There is a comprehensive in-service education programme that meets requirements and covers relevant aspects of care and support. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards through Careerforce Staff performance is monitored through annual performance appraisals.

Residents’ admission information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to data and relevant consumer records.

### Continuum of Service Delivery

The Te Arahina O Arihia Rest Home Residential Care Handbook contains information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family/whanau.

The activities programme includes a diversity of activities and involvement with the wider community is enjoyed by residents.

Well defined medicine policies and procedures guide practice which is demonstrated to be consistent with these documents.

Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided. Snacks are available over a 24 hour period.

### Safe and Appropriate Environment

The facility is appropriate to the needs of the residents and fit for purpose. The buildings, facilities, furnishings and equipment are well maintained and suitable for the care and support of the residents. Applicable building regulations and requirements are met. Bedrooms provide single and double accommodation. There is an adequate number of toilet and shower facilities throughout the facility in each of the units. Residents' rooms are large enough to allow for the safe use of mobility and lifting aids. There are lounges and sitting areas throughout the facility as well as a dining room in each unit. Outdoor areas are available and seating and shading is provided. The external area for dementia residents is secure. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic. Staff receive education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. Laundry services are contracted to an external provider and monitored for effectiveness.

### Restraint Minimisation and Safe Practice

Documentation of policies and procedures, staff training and the implementation of the processes demonstrate that residents are experiencing services that are the least restrictive. There are three residents using restraint and one resident using an enabler. The service has processes in place for determining restraint approval, consent from family and evidence of an assessment, monitoring and evaluation. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Residents’ files show that there is family input into the restraint approval processes. Staff have training in managing challenging behaviour and restraint and were observed to be skilled in the use of de-escalation techniques.

### Infection Prevention and Control

Te Arahina O Arihia Rest Home has a clearly defined infection prevention and control programme for which external advice and support is available. An infection control nurse and the rest home manager are responsible for ensuring implementation of this programme, including education, surveillance and reporting.

The programme implements policies and procedures aimed at establishing, maintaining and monitoring infection control practices and this is reviewed annually. Service providers receive education on infection control as part of the orientation programme and ongoing education is provided by the infection control nurse.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance. An area of continuous improvement has been identified through initiative that has resulted in a reduction in urine 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:** | Taumarunui Community Kokiri Enterprises Limited |
| **Certificate name:** | Taumarunui Community Kokiri Enterprises Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Te Arahina O Arihia Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 10 April 2013 | **End date:** | 11 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:** | 18 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 12 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 4 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 24 | Total audit hours | 56 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 9 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 21 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## Declaration

I, XXXXX, Director of Wellington 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 Tuesday, 29 April 2014

## Executive Summary of Audit

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| **General Overview** |
| Te Arahina O Arihia Rest Home is a 25 bed aged care facility providing rest home and dementia level care. Occupancy on the day of the audit was at 18. The facility is operated by Taumarunui Community Kokiri Trust. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed were very positive about the care provided and staff being very supportive. There have been no changes in the facility, staffing structure, management or systems since the last audit.   One area has been rated as continuous improvement (beyond the standard normally expected) relating to a quality initiative implemented to reduce the rate of urinary tract infections in the facility. There are no areas identified as requiring improvement during this audit. |

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| **Outcome 1.1: Consumer Rights** |
| Support provided at Te Arahina O Arihia Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected.  Te Arahina O Arihia Rest Home supports residents who identify as Maori and have appropriate policies, procedures and community connections to ensure culturally appropriate support is available.  Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents and family/whanau are kept informed.   Access to advocacy services is available through the local community support agencies. Te Arahina O Arihia Rest Home encourages residents to maintain connections with family/whanau and their community.  The manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' monthly meetings. Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised. |

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| **Outcome 1.2: Organisational Management** |
| The purpose, values, scope, direction and goals of the organisation are displayed and reflect the services provided. Day to day operations are the responsibility of the manager who is a registered nurse (RN) and who has appropriate skills and experience. The manager is supported by a registered nurse who assists with oversight of clinical care. Registered nurse cover is provided six days a week.   The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated during regular staff meetings and manager reports. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and managed.  Human resources management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hour period with experienced advice and assistance available. Sufficient orientation/induction is in place for staff. There is a comprehensive in-service education programme that meets requirements and covers relevant aspects of care and support. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards through Careerforce Staff performance is monitored through annual performance appraisals.   Residents’ admission information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to data and relevant consumer records. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The Te Arahina O Arihia Rest Home Residential Care Handbook contains information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.  There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family/whanau.  The activities programme includes a diversity of activities and involvement with the wider community is enjoyed by residents.  Well defined medicine policies and procedures guide practice which is demonstrated to be consistent with these documents.  Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided. Snacks are available over a 24 hour period. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility is appropriate to the needs of the residents and fit for purpose. The buildings, facilities, furnishings and equipment are well maintained and suitable for the care and support of the residents. Applicable building regulations and requirements are met. Bedrooms provide single and double accommodation. There is an adequate number of toilet and shower facilities throughout the facility in each of the units. Residents' rooms are large enough to allow for the safe use of mobility and lifting aids. There are lounges and sitting areas throughout the facility as well as a dining room in each unit. Outdoor areas are available and seating and shading is provided. The external areas for dementia residents is secure. An appropriate call bell system is available and security systems are in place.  There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic. Staff receive education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. Laundry services are contracted to an external provider and monitored for effectiveness. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Documentation of policies and procedures, staff training and the implementation of the processes demonstrate that residents are experiencing services that are the least restrictive. There are three residents using restraint and one resident using an enabler. The service has processes in place for determining restraint approval, consent from family and evidence of an assessment, monitoring and evaluation. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Residents’ files show that there is family input into the restraint approval processes. Staff have training in managing challenging behaviour and restraint and were observed to be skilled in the use of de-escalation techniques. |

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| **Outcome 3: Infection Prevention and Control** |
| Te Arahina O Arihia Rest Home has a clearly defined infection prevention and control programme for which external advice and support is available. An infection control nurse and the rest home manager are responsible for ensuring implementation of this programme, including education, surveillance and reporting.   The programme implements policies and procedures aimed at establishing, maintaining and monitoring infection control practices and this is reviewed annually. Service providers receive education on infection control as part of the orientation programme and ongoing education is provided by the infection control nurse.   Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance. An area of continuous improvement has been identified through initiative that has resulted in a reduction in urine infections. |

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 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)** |
| --- | --- | --- | --- | --- | --- | --- |
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## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(IPC)S.2008 | Criterion 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. | CI | Implementation of the infection control quality initiative regarding urinary tract infections (UTI’s) has resulted in a decrease of UTI’s. |

# 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:** |
| Te Arahina O Arihia rest home is observed to provide an environment in which residents receive services in accordance with human rights legislation. Residents receive an information pack on admission that identifies; the services provided by Te Arahina O Arihia and how to access those services, information on the Code of Health and Disability Services Consumers Rights (the Code), information on accessing the Nationwide Health and Disability Advocacy Service, applying for a subsidy, the complaints procedure and how to access further information in regards to services if required. The information pack and brochures are displayed and available to the public at the front entrance.   Staff receive education on the Health and Disability Commissioner’s Code at orientation and through in-service and on line training sessions as sighted in five of five staff orientation, training records and planned education programmes, and verified by ten of ten staff interviews. Situations observed during the audit in relation to the provision of care, saw residents being given choices, residents' decisions being respected, residents being treated with respect, residents' privacy being protected (eg, notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and residents being addressed by a preferred name. Those residents in shared rooms, are sharing with family members or those of similar interest, have agreed to share a room, have curtains between beds and have access to the whanau room for privacy if required.  Clinical staff are observed to explain procedures being undertaken and seek verbal acknowledgement for the procedure to proceed prior to it being commenced.    Compliance with the Code is monitored through resident meetings (minutes sighted) audits and observation.   Interviews with three of three family/whanau members and/or power of attorney (POA) (two of these being family members/POA to residents in the dementia unit and with the other related to a rest home resident) and five of five rest home residents confirm satisfaction with the service fulfilling its obligations under the consumer rights legislation. They report that they are treated with respect, cultural wishes are acknowledged, privacy maintained and they are not exposed nor have they observed any abuse or discrimination.   The 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:** |
| Te Arahina O Arihia Rest home provides an environment in which residents are informed of their rights. Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) in the Te Arahina O Arihia Rest home Residential Care Handbook which outlines the services provided by Te Arahina O Arihia Rest home, the Nationwide Health and Disability Advocacy service and information on applying for a residential care subsidy. Access to interpreters through Taumarunui hospital is available should assistance be required to provide the information in a language and format that is suitable to the consumer.   When a resident is admitted, the admission process includes discussion related the content of admission pack information and the details in the admission agreement. Admissions are undertaken by the Registered Nurse (RN) or the Manager (RN) as verified by the family/whanau of one of one rest home and two of two dementia unit residents and five of five rest home residents interviewed.  Discussions relating to residents' rights and responsibilities take place formally (in residents meetings and training forums) and informally (with the resident in their room). Education is held and opportunities for discussion and clarification relating to the Code are provided to residents and their families/whanau (confirmed by interviews with the registered nurse and manager).   The ARRC requirements are met. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Te Arahina O Arihia rest home provides an environment in which consumers are treated with respect and receive services that has regard for their dignity, privacy and independence.   Single bedrooms allow privacy for residents at any time. Double bedrooms in the rest home and dementia are available to accommodate couples or friends. There are curtains between the beds enabling privacy and residents and family/whanau have access to a whanau room if more privacy is required. Bedrooms are of a size that allow appropriate storage of personal belongings. A double bedroom in the dementia unit is occupied by two residents. Interviews with both family/whanau members verifies agreement with this arrangement. Interview with one of one registered nurse verifies evidence to support the appropriateness of these residents sharing a room.   As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their room, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff always knock on their door prior to entering. A locked area provides privacy of stored information in both areas. Privacy when discussion concerning residents takes place is in residents' rooms or in the whanau room. Staff education on privacy takes place at orientation, and during in-service education as verified by five of five staff files, sighted planned education programmes and 10 of 10 staff interviews.  Care plans identify residents like and dislikes and interventions identify the assistance the resident requires to meet residents' needs.   Residents are addressed in a respectful manner and by their preferred names (confirmed by observation and in interviews with five of five rest home residents and three of three family members). Residents are assisted to maintain dignity and respect and to ensure the residents' sexuality and intimacy needs are both supported and protected, while protecting the wellbeing of others. Residents are encouraged by staff to be as active as is safely possible.  The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. The culural assessment form (sighted) includes consideration for alternative remedies, requested and approved by the GP. Staff demonstrate an awareness of the need to provide a service that is responsive to these needs. Residents and families receive clinical services that have regard for their dignity, privacy and independence.  Consumers are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. As confirmed by 10 of 10 staff interviews, all staff said they would report anything of concern to management. Interviews with three of three family/whanau members and five of five residents, confirm they have no concerns related to abuse or neglect. All comments are positive. Education on abuse and neglect was presented in 2013 and is due May 2014. Cultural awareness training is due December 2014   Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives. Evidence of this is sighted in five of five rest home and two of two dementia residents files, resident, family and staff interviews and confirm services implemented enable the residents privacy, independence dignity and respect.  The ARRC requirements are met. |

##### 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:** |
| Te Arahina O Arihia Rest Home is operated by the Taumarunui Community Kokira Trust. Te Arahina O Arihia Rest Home recognises the special relationship between Iwi and the Crown and appreciates the principles of The Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing.  There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organisations model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service.  Two of two residents at Te Arahina O Arihia Rest Home who identify as Maori, have a comprehensive plan of care documented that supports their cultural needs, as verified by file review and resident interview.  Local Maori health providers support the facility and present education and advise related to cultural safety. Staff receive annual education in relation to Cultural Safety and The Treaty of Waitangi.  The requirements of the ARRC 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:** |
| Te Arahina O Arihia Rest Home provides an environment that enable consumers to receive culturally safe services that recognise and respect individual ethnic, cultural and spiritual values and beliefs.  Included in the admission and ongoing assessment process the resident's specific cultural and spiritual needs, values and beliefs are identified and documented to inform the care planning and activity planning process to ensure that specific needs and objectives are met.  Residents and/or family/whanau or their nominated representative are consulted about individual values and beliefs to ascertain if there are any special requirements needed to be met by the service, as verified by seven of seven files reviewed (five of five rest home and two of two dementia unit residents) resident (five of five rest home) family/whanau (one of one rest home resident and two of two dementia unit residents) and staff interviews (four of four clinical, two of two activities and one of one cook). One of one rest home resident has documented alternative remedies, supported by the GP, included in the care plan.   Yearly in-service training is provided on cultural safety (sighted). A multi-denominational church service is sighted in the activities programme. Some residents access their own spiritual support from the community.  Open visiting policy allows family/whanau to visit when they are able.  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:** |
| Te Arahina O Arihia Rest Home provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.  Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date, as verified by five of five rest home residents, family/whanau (one of one rest home resident and two of two dementia unit residents) interviews.  Orientation/induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements, as evidenced in five of five staff files. Ten of ten staff interviews verify knowledge of the discrimination policy. The manager will action formal disciplinary procedure if there is an employee breach of conduct.  The ARRC requirements are met |

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

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

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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:** |
| Te Arahina O Arihia Rest Home provides an environment that encourages good practice. All policies sighted are up to date and relevant reference is made to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales, which are monitored and evaluated at organisational and facility level.  New employees complete a comprehensive orientation/induction programme that is relevant to the role they undertaken. The service supports and encourages staff with appropriate on-going education either off site, on-site, on-line and relevant to the role they undertake. The service has an in-service education programme in place which is monitored at organisational level to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. All care staff have or are undertaking the National Certificate in Support of the Older Person. All registered nurses (RN)s and senior care staff who administer medication have yearly assessments to determine competency. All staff has an up to date first aid certificate (sighted). Registered nurse education is supported by District Health Board, the specialist services that they operate and the local Hospice services. All staff working in the dementia unit has formal qualifications in caring for a person with dementia.   The activities personnel have no formal diversional therapy training however are supervised by a trained Diversional Therapist. The newly appointed Activities Person in the dementia unit is enrolled to commence her Diversional Therapy training.   The cooks (2) have food safety training and evidence of this is sighted.   10 of 10 staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner.  Residents and relatives verify satisfaction with the services provided. Resident satisfaction surveys undertaken annually indicate overall the satisfaction is high. The 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:** |
| Te Arahina O Arihia Rest Home provides an environment conducive to effective communication. Communication with relatives is documented in a family/whanau communication sheet, copies of which are kept in the residents' files (completed forms are sighted in five of five rest home residents' and two of two dementia unit residents files reviewed).   Te Arahina O Arihia Rest Home has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Two of two healthcare assistants interviewed (one from the rest home and one from the dementia unit) confirm they understand that relatives and residents must be informed of any changes in care provision. Five of five residents and three of three family/whanau members interviewed, confirm that they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews. Evidence of open disclosure is documented on the incident and accident forms sighted. Residents and family confirm communication with staff is open and effective (verified in five of five resident and three of three family/whanau interviews, and sighted during audit).   There are no residents that require interpreting services; however the manager is aware of how to access interpreters if this service should be.  Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau. Staff make adequate time to talk with residents and families (confirmed in interviews with two of two care staff, the RN, five of five residents and three of three family members). There is sufficient space in each single room to permit private discussions or the whanau room for residents in a double room. At admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about and at what time of day they wish to be notified.  The ARRC requirements are met. |

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

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

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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:** |
| Te Arahina O Arihia Rest Home provides residents and where appropriate their family/whanau with the information they need to make informed choices and give informed consent.   Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/ whanau on admission. Consents requests the resident's agreement to collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised by Te Arahina O Arihia Rest Home. Informed consent is evident in observation of day to day activities on the two days of audit, with residents being actively involved in the decision making process. A double bedroom in the dementia unit is occupied by two residents. Interviews with both family/whanau members verifies agreement with this arrangement. Seven of seven files (five from rest home and two from the dementia unit) reviewed evidenced informed consent forms signed on admission. Ten of ten (six from the rest home and four from the dementia unit) medicine charts have residents photographs for identification. Documentation identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. The consumer satisfaction survey results indicate family/whanau satisfaction with involvement in care.  An advanced directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advanced directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non-consent to be revoked at any time. Advanced directives, active therapy requests and in the event of death directives, are sighted in five of five rest home files and two of two dementia residents files (the dementia residents request acknowledges competence when signed, prior to admission.   Verbal consent is obtained prior to an intervention being carried out (confirmed in interview with five of five rest home residents and three of three family/whanau members).   Staff education on consent takes place during their orientation and during in-service education. Staff has an understanding of the informed consent process (confirmed in interviews with two of two care staff). The manager, one of one RN, two of two caregivers, two of two activities officers and five of five residents, confirm their understanding and knowledge of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. Staff respect residents' choices and allow residents to change their mind at any time. Examples are sighted related to respecting residents' wishes; to attend chapel, food likes and dislikes being catered for, activities in the activities programme (individuals involvement is at the resident's request), and an environment where choices are openly acknowledged and offered. All five of five resident and three of three family/whanau interviews confirm their choices are respected by staff and staff confirm they respect the resident's right to decline any services offered.  Seven of seven care plans sighted are signed by the resident and/or family whanau/POA, where appropriate, to say they have read and agree with what is written.  The 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:** |
| Te Arahina O Arihia Rest Home recognises and facilitates the right of residents to advocacy/support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is included in the admission information. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons, as verified in resident and family interviews.  Staff demonstrate appropriate knowledge related to the resident's right to have an advocate or support person of choice at any time, as verified by two of two caregivers, one of one nurse manager, and one of one RN.  The Quality Coordinator runs the monthly residents' meetings, when residents express any concerns needing to be addressed, she will invite the service concerned to attend the meeting to enable a solution to be put in place. Residents and families interviewed are happy with how the service addresses any concerns they have.  The 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:** |
| Te Arahina O Arihia Rest Home provides an environment whereby consumers are able to maintain links with family/whanau and their community and residents are encouraged to maintain these links. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources. Residents freely go to and from the local shops where able.    Residents are assisted and encouraged to maximise their potential for self-help and involvement in the wider community by attending a variety of organised outings, visits, activities, and entertainment at various locations in the local and wider community.   The service acknowledges values and encourages the involvement of families/whanau in the provision of care. The activities programme actively supports community involvement and accesses community resources. Five of five residents and three of three family members confirm that visitors can visit freely and there is free access to community services.   File reviews, and interviews with the manager and the recreational officer confirm community services used by the facility include: - residents attend medical centres to consult with their own GP. - local social groups,  - the local community centre activities - other aged care facilities - local church groups and services - the Waikato DHB nurse specialists - Disability and support links - the local needs assessment and service coordination agency (NASC)  - Residents access external podiatry and physiotherapy services - Waikato DHB outpatient and inpatient services as appropriate.  The 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:** |
| The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there is one complaint recorded for 2013 and 2014.  Reporting of complaints occurs via monthly quality and staff meetings and via the manager’s monthly operations reports to the Taumarinui Community Kokiri Trust. The manager reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.   Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly. Review of these minutes provides evidence of the residents’ ability to raise any issues they have, and this was confirmed during interviews of residents.  A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of the quality and staff meeting minutes and the manager's monthly reports provides evidence of reporting of complaints.  The District Health Board contract requirements are met. |

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

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

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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:** |
| Taumarunui Community Kokiri Trust is the governing body and is responsible for the service provided at Te Arahina O Arihia Rest Home. A ' Strategic Plan 2013 – 2015’ and a ‘Quality Plan 2013-2015’ is reviewed and includes a vision statement, philosophy, purpose, core values, ‘swot’ analysis, operationa/performancel objectives, quality objectives, quality indicators, scope of service and an organisational chart. Taumarunui Community Kokiri Trust has established systems in place which defines the monitoring and reporting processes against the Strategic Plan.   Documented values, mission statement and philosophy are also reviewed and these are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.   Meeting schedules and minutes reviewed show that quality and staff meetings are held monthly and resident meetings are held two monthly. Meeting minutes are available for review by staff along with clinical indicator reports and graphs.  The manager provides monthly reports to the governing body and these are reviewed during this audit. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.  Te Arahina O Arihia Rest Home has a manager who is an RN who was been in this role for six years. Prior to this appointment the manager was a care giver at this facility before completing their RN training. The manager is supported by a full time RN, and an enrolled nurse (EN) who is the team leader in the dementia unit.  Review of the manager’s personal file and interview of the manager indicates the manager undertakes training in relevant areas. RN cover is provided six days a week as well as after hours if required. Support for the manager is provided by the staff at the ‘Trust‘ office and also practice nurses from the two GP rooms that the ‘Trust’ is the governing body for. The manager also holds a monthly ‘Team Leader’ meetings where peer supervision is undertaken with other managers/RNs within the organisation.  Te Arahina O Arihia Rest Home is certified to provide rest home level care and rest home dementia level care. There are 25 beds and on the day of this audit there are 12 rest home residents and 6 dementia care residents residing in the facility.  Taumarunui Community Kokiri Trust has contracts with the DHB to provide aged related residential care (rest home), and day care and respite care; and with the Ministry of Health to provide residential – non aged and day programmes – non aged   The District Health Board 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:** |
| There are appropriate systems in place to ensure the day-to-day operation of the service continues should the manager be absent. The RN who works full time and has previous rest home management experience fills in for the manager if they are absent and is interviewed during this audit. The RN assumes responsibility for clinical management and they are supported by the administrator and ‘Trust’ staff who assume responsibility for non-clinical management in the absence of the manager. The manager is on call, with back up from the RN.  Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the manager, RN and administrator confirm their responsibility and authority for their roles.  The District Health Board contract requirements are met. |

##### Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

#### Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A 'Quality Plan for Te Arahina O Arihia Rest Home 2013 – January 2015’ is used to guide the quality programme and includes quality goals and objectives. Taumarunui Community Kokiri Trust has an established, documented, and maintained quality and risk management system.   There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to the ‘Trust’ via monthly reports. Quality improvement and staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Clinical indicators are recorded on various registers and forms and are reviewed during this audit. There is documented evidence of collection, collation, analysis for trends and corrective actions completed. Reporting of quality improvement data occurs, including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified occurs in the monthly quality and staff meetings. Resident meetings are held two monthly.   As part of the process the service provider has identified an area that requires improvement and undertaken a quality improvement project that includes monitoring and evaluation to ensure the improvements required have been made. There is evidence available including evidence of improvements to service delivery as a result of this quality improvement project. As a result, criterion (3.5.7) is rated continuous improvement.  Staff interviewed report they are kept informed of quality and risk management issues, including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office, and include graphs.  Resident and family satisfaction surveys and activities surveys are completed six monthly. Collated results are reviewed and indicates high levels of satisfaction.  The manager is responsible for providing a monthly report to the ‘Trust’ and these provide evidence of reporting of clinical indicators and quality improvements - including education, staffing, issues and concerns, and internal audits.   Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service and reflects current accepted good practice and references legislative requirements. Policies and procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Policies and procedures are reviewed by the management following consultation with clinical personnel. A staff signing sheet demonstrates staff have been updated on new or reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed (two caregivers and one RN and one EN) confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.   A health and safety manual is available that includes relevant policies and procedures and is reviewed during the audit. Risks are identified and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. Chemical Safety Data Sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed and all biomedical equipment have appropriate performance verified stickers in place and/or calibration reports.  The District Health Board 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:** FA |
| **Evidence:** |
| The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are reviewed by the manager and RN and are then recorded on an ‘Incident Summary’ for each type of event. The incident/accident form is filed in the residents’ files. 2013 and early 2014 data is reviewed and includes summaries and registers of various clinical indicators, including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events. A monthly summary of incidents is reported to the ‘Trust’.  There is an open disclosure policy. Residents’ files reviewed (five rest home and two dementia) provide evidence of communication with families following adverse events involving the resident, or any change in a resident’s condition.   Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, and this is confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).  The District Health Board contract requirements are met.. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Written policies and procedures in relation to human resources management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which are reviewed on staff files (five of five) along with  reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments (as appropriate), and annual practising certificates for the manager/RN, RN and EN.   The manager is responsible for management of the in-service education programme and there is evidence available indicating in-service education is provided for staff at least once a month. This education is supplemented with e-learning via an external agency that has developed 22 learning modules that are specific to the aged-care sector. The manager advises they select different modules each month and staff are required to complete and return the learning material for each module by the end of each month. The manager advises they also provide onsite education sessions to assist staff complete these learning modules. The enrolled nurse (EN) is the Careerforce assessor and staff are supported to complete the modules. Staff working in the dementia unit have the required dementia related modules.  Individual records of education are maintained for each staff member and copies are reviewed on staff files. Also viewed competency assessment and education spread sheets as well as education records for each session and in-service education programmes. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed. Current annual practising certificates are reviewed in a register for staff who require them to practice (i.e. RNs, EN, pharmacist, dietitian, and general practitioners (GPs)).   An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The manager advises that staff are orientated with a ‘buddy system’. The entire orientation process, including completion of competencies, takes up to three to four weeks to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff complete an orientation questionnaire that includes medication competency, fire safety, manual handling, and hand washing. Policy and procedures, the physical layout of the facility, the authority and responsibility of their individual positions, the organisation’s vision, values and philosophy are also included.  Care staff interviewed (two caregivers who work both morning and afternoon shifts, one RN and one EN) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.  The Distruct Health Board 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:** |
| There is a documented rationale (Staff Numbers and Skill Mix Policy) for determining service provider levels and skill mix. The roster is reviewed and confirms that staffing levels reflect the number and mix of residents, acuity of residents, lay out of facility, staff skills and experience. All care staff are required to complete the dementia training.   The minimum number of staff is provided during the night shift and consists of two caregivers. One is situated in the dementia unit and one in the rest home. The manager/RN is available during office hours and on call 24 hours a day with back up from the RN. Residents and staff interviewed confirm that adequate staff are accessible at all times.  The District Health Board 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:** |
| Residents admitted to Te Arahina O Arihia Rest Home have the information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission (evident in five of five rest home and two of two dementia patient files reviewed). The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.   All records sighted are secure. Rest home residents' current files are stored in a key pad locked office and dementia residents’ current files are stored in a key pad locked cupboard. Archived files are in a locked room, and easily accessible. Resident information is kept in hard copy format. The registered nurse deals with resident file content. A standard format is in use for file documents and includes the resident’s admission agreement, admission form, general consent and identification of the General Practitioner (GP), Disability and Support Links (DSL) assessment and enduring power of attorney (EPOA) or POA. Any correspondence from other service providers is kept in the progress notes until any contact or action from these providers has occurred. The service is not responsible for NHI numbers.  The service receives referral information from Disability and Support Links (local NASC) which includes relevant assessment and medical information. This information is used to develop individual resident’s files.  The administrator keeps a register of past and present residents which includes details of name, NHI, DOB, GP and room number plus admission date and address, Next of Kin (NOK) and date left service (including discharge address) and or deceased. This is then saved and archived when a new resident is admitted to ensure the register is always up to date.  All relevant ARRC requirements are met. |

##### 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:** |
| Te Arahina O Arihia Rest Home provides an environment whereby when the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.   Access and entry criteria are documented and communicated to consumers and their family/whanau by local doctors, referral agencies, DHB hospital and local community groups. Service availability and related information is available through the Disability and Support Link Needs Assessment and Service Co-ordination (DSL) agency, the local GPs, on site and on the Eldernet website. The admission and pre-admission documentation includes information about the services provided, its location, hours, how service is accessed, residents’ rights and responsibilities, including information on the Code of Health and Disability Services Consumers’ Rights, the availability of cultural support, after hours or emergency contacts if needed, and identifies the process if a resident requires a change in the care provided.   Prior to entry, the resident is assessed by the DSL agency to ensure the client requires the care provided at Te Arahina O Arihia Rest Home. Te Arahina O Arihia Rest Home has a good working relationship with DSL, doctors and community agencies who are aware of the level of care offered and the process required to access that care. The service operates twenty four hours a day seven days per week  The prospective resident information pack includes information on the Residential Care Subsidy and information specific to this provider.  If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency (Disability and Support Link). All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents when they call in. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the nurse manager or RN.  Five of five rest home resident and two of two dementia residents’ files reviewed contain completed assessments by DSL verifying placement is required. Two of two residents in the dementia unit have a Power of Attorney authority in place. Admission agreements meet contractual requirements.   The ARRC contract requirements 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:** |
| Te Arahina O Arihia Rest Home has a clear process for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, the resident and family will be assisted to find a facility offering that care, by DSL and the facility, if required.   Te Arahina O Arihia Rest Home has a close relationship with DSL and referring agencies. These agencies are informed of the bed status and are familiar with the type of environment offered and the type of residents it would suit, declining entry to service is unlikely to occur.   The admission agreement details the process in place if a resident of Te Arahina O Arihia requires care greater than that provided at the facility.   The ARRC contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission to Te Arahina O Arihia an initial assessment, including information from the resident, their nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services, is gathered and documented by the registered nurse within 24 hours of admission. This serves as the basis for care planning to cover a period of up to three weeks, by which time the registered nurse completes a long term care plan, based on the collection of more detailed assessment data. Staff accompany the resident to a medical assessment which is conducted off-site at the medical centre of the resident’s own general practitioner (GP) within 24 hours of admission and the treatment programme required by the resident is documented. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. Evidence of this is sighted in five of five rest home and two of two dementia residents files.  The long term care plan directs the care required to meet the resident’s need and desired outcome. The assessment, care plan and evaluation is completed and documented by the registered nurse in consultation with the resident, family/whanau, power of attorney and allied professionals. Re-assessment, review and evaluation of residents and their needs is ongoing, by a RN, and occurs as needs change or every six months. Evaluation includes consultation with the resident, the GP, family/whanau and or power of attorney, to determine the resident's degree of progress towards the desired goals and initiated changes where progress differs from that expected. Changes to the plan, are evidenced to involve the resident and/or family/whanau and power of attorney if requested, by signage on the care plans and documented family/whanau communication records of phone calls or conversations. Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews with five of five rest home residents, one of one rest home family/whanau member and two of two dementia residents family/whanau member.   Health professionals delivering the daily care to residents, write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals and is responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in one resident's file, where specialist input is required. Short term care plans are used for any short term problems such as urine infections or wounds.   Two of two registered nurses and one of one enrolled nurses practising certificate, medication competencies and first aid certificates are sighted in addition to first aid certificates for all staff and medication competencies for all senior care staff. The registered nurses are evidenced to have attended ongoing professional development and training, including training related to care of residents with dementia. Caregivers working in the dementia unit are evidenced to hold qualifications in dementia training. Caregiving staff working in the rest home are sighted to have or be working towards the National Certificate in Care of the Older Person offered by Careerforce and overseen by an onsite assessor.   Both the rest home and dementia unit each have an activities person employed from Monday to Friday. Neither of these staff have formal training at this time, though are mentored by a trained Diversional Therapist on and offsite. The activities person working in the dementia unit has only been in the role six weeks and is enrolled to commence her Diversional Therapy training. The in-service and on-line education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks (2) have recently updated food safety training (records sighted). The local physiotherapist and podiatrist provide servicesto residents off site as needed.  Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The registered nurse acts as the resident’s case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. Allocated caregivers are the residents’ key worker for a week to ensure continuity. Key workers have a direct responsibility for attending to individual residents’ needs. A verbal handover by the senior nurse (observed) that includes a printed recent update of each resident occurs at the beginning of each shift to ensure all staff is familiar with the resident needs, as verified by interview with two of two care staff (one from each area). An on call report sheet, documents a record of calls made to the RN on call.   The ARRC contract requirements are met.  Tracer methodology 1 – Rest Home XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology 2 – Dementia unit XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' of Te Arahina O Arihia have their needs identified through a variety of information sources that includes the DSL assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered informs the care planning process.  Within 24 hours of admission an initial assessment is undertaken by the RN to identify immediate need and plan the care required to meet these. This takes place in the privacy of the resident’s bedroom or the whanau room with the resident and/or family/whanau present if requested. Over the next three weeks, the RN undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care planning. This is verified by interviews with five of five rest home residents, one of one rest home family/whanau members, two of two dementia residents’ family/whanau members and two of two registered nurses. The assessment is reviewed six monthly or as needs, outcomes and goals of the resident change .  Residents are accompanied to enable a medical assessment to be undertaken by the residents own GP at the GP’s rooms within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable.  Five of five resident and three of three family/whanau interviews (one of one rest home and two of two dementia), verify residents and family are included and informed of all assessment updates and changes.   One of one care staff who works in the dementia unit and one of one care staff who works in the rest home interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.   Multidisciplinary meetings are held yearly and include the resident, family/whanau/POA and Te Arahina O Arihia Rest Home staff. This is a time for discussion, for the resident to discuss their goals and for the team to plan to assist the resident achieve their goals (documentation sighted).   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care plan is developed in consultation with the resident and/or family/whanau, documents the plan of care identified by initial and on-going individual assessments, and identifies appropriate resident or power of attorney guided interventions to enable the resident to meet their need, goal and desired outcome.  Residents have one set of clinical notes in which all providers involved with the resident’s care use to document the resident’s progress. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, handover sheet and the resident's care plan.  Care plans are evaluated six monthly or more frequent as the resident's condition dictates. Short term care plans, document the existence of short term problems and the required intervention. Information from the assessment process informs the allied services of resident need. The kitchen is informed of needs regarding nutrition and activity assessments inform the activities officer of interventions required in the activities programme.  The staff education records sighted validate that staff receive appropriate training to deliver the care residents require. Training records evidence education that includes Code of Rights, delirium, infection control, wound care, end of life care, restraint minimization and safe practice, elder abuse and neglect and management of challenging behaviour. The RNs participate in the Professional Development Recognition Programme and attend other off site training opportunities. Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. Timely access to other health providers is evident in two of the residents' files, where specialist input has been sought.  The ARRC requirements are met. |

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

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

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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:** |
| The care and services Te Arahina O Arihia Rest Home are delivered in a safe and respectful manner. New residents are welcomed and orientated to the facility (confirmed at interview with five of five rest home residents and two of two dementia residents’ family members interviewed). The care plan documents the care the resident requires to meet the resident’s assessed needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.   The provision of care is consistent with the desired outcomes in all five of five rest home residents and two of two dementia residents files reviewed which document the resident’s physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.  Interviews with five of five residents, one of one rest home and two of two dementia family/whanau members expressed satisfaction with the admission process and felt welcomed. They were very happy with the care and the respect shown to them and their relatives. There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident’s needs (sighted).  The facility has no contracted GP service. Each resident attends, with staff supervision, the medical practice of their selected GP. One GP was attempted to be contacted numerous times for interview on the days of audit but was too busy to be interviewed.   Appropriate links with other services are maintained. The Waikato DHB clinical nurse specialists and hospice nurses are available for advice, consultation and review. There is evidence of referrals to specialist services and specialists input in residents’ files   Podiatry and physiotherapy services are accessed in the community when required.   The RN interviewed describes the transfer procedure and explains that resident’s care plans summary and medication charts are photocopied and accompany the resident when transferred. An after-hours medical service is not available and transfer to the local DHB service is used if medical input after hours is required.   The 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:** |
| On admission, residents to Te Arahina O Arihia Rest Home are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident’s preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programmes sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.  Both the rest home and dementia unit each have an activities person employed from Monday to Friday. Neither of these have formal training at this time though are mentored by a trained Diversional Therapist on and offsite. The activities person working in the dementia unit has only been in the role six weeks and is enrolled to commence her Diversional Therapy training.  Activities in both the rest home and dementia unit reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, visits to the local returned services association club, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate. One on one activities are included in both programmes, whereby residents are taken out by themselves to attend an activity they or their POA specifically requests.  Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the resident’s response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family/whanau or power of attorney, where appropriate. Five of five rest home residents, one of one rest home family member and two of two dementia residents family member expressed satisfaction at the activities offered and the outings organised.   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:** |
| Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may arrange for the resident to see the GP if required. Family/whanau are kept informed of changes. Normal care plan evaluations are conducted at least six monthly or as needs change. Evaluation is undertaken to measure the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan.  A short term care plan is initiated for short term issues, such as infections, wound care and changes in the resident’s general condition. There is evidence in the resident’s integrated notes that family are involved in the evaluation process and this is also verified in five of five resident interviews and one of one rest home and two of two dementia resident family/whanau/POA interviews.  The RN undertakes and documents all care plan evaluations, at least every six months (this is sighted in all files reviewed).   The ARRC requirements are met. |

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

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

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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:** |
| Resident support for access or referral to other health and/or disability service providers is facilitated byTe Arahina O Arihia Rest Home to meet consumer need. If the need for other services are indicated or requested, the GP or RN looks to seek specialist service provider assistance from the local hospital or Waikato DHB specialist services. The resident and the family are kept informed of the referral process.   Residents are supported to access other health and/or disability support services as required or requested. The facility has access to a van that can escort residents to appointments. Residents and their families are given a choice and advised of their options to access other health and disability services where indicated or requested. A record of this is maintained. If the need for other services are identified these services are sought, with the resident and/or family supported to do so. A client file reviewed required assistance to access specialist health services out of the region. Sighted in two of two client files, information relating to assistance in accessing that service. The RN and the manager reports that residents are given the choice of changing facilities if they are not happy and also if their health needs change. Residents are supervised by staff to access their GP’s of choice at the GP’s rooms. A record of the consultation and findings and updated medication chart is kept onsite at Te Arahina O Arihia Rest Home.   Any non-urgent referrals sent, are followed up on a regular basis by the registered nurse. Residents and families are kept informed of the likely wait times. Where possible a family member accompanies the resident. There is no after-hours medical cover, acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed as verified by five of five rest home resident interviews and three of three family interviews (two dementia residents family and one rest home).  The 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, discharge or transfer from Te Arahina O Arihia Rest Home is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There is a specific transfer form that records all the relevant information needed when transferring a resident, including whanau notification, a copy of the medication chart and signing sheets, a copy of progress notes, a copy of doctor’s notes and a power of attorney form. If the resident is transferring to a DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes. The resident's family is notified of the upcoming appointment and will be invited to attend and assist (verified in resident and family interviews) unless the resident requests otherwise.   The ARRC requirements are met |

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

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

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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:** |
| Residents at Te Arahina O Arihia Rest Home receive their medicines in a safe and timely manner that complies with legislation and safe practice guidelines which are consistently followed. Medicines are dispensed and delivered by the pharmacy in the Pharmaceuticals Medico Pak delivery system. All medicines are prescribed by the GP. Each resident has an individual medicines profile that includes a photograph and any documented allergies, medicine prescription form, an individually dispensed Medico Pak for their medicines and medicine signing sheets. The received medicines are checked by the RN for accuracy when medicines are delivered.  Medications not in use or out of date are returned to the pharmacy.   The safety of residents, visitors, staff and contactors is maintained through appropriate storage and access to medicines. In each area (dementia and rest home) medicines are stored securely and there is locked secure medicine trolley to store medicines in. Storage of stock medications is in a locked cupboard. Controlled drugs are stored in a separate locked metal container in a locked cupboard. Controlled drugs, when dispensed, are checked by two nurses, one of which is medication competent for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly stock take and reconciliation recorded.   Interview and observation of the RN undertaking medicine administration on the day of audit verified awareness of the role and responsibilities related to all aspects of medicine management and the regulations concerning administration of controlled drugs. Contents of the medicine pack are observed as checked against the medicine order.   10 of 10 medicine charts are reviewed (six of six rest home and four of four dementia) and have each medicine signed for when dispensed (or the reason why the medicine was not given) recorded on the signing sheet. There is a specimen signature register maintained for all staff who administers medicine. The medicine charts reviewed have allergies and sensitivities recorded in a prominent position. A recent photograph of the resident is sighted for identification. Each medicine is signed individually by the GP, records date of the order, medicine, strength, dose, time, route, frequency and duration. Medicine reviews by the GPs are recorded on the medicine chart, which is reviewed and updated at least three monthly.   Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in the five of five rest home and two of two dementia files reviewed. The manager and RN are not aware of any recent drug errors  Documentation is sighted verifying competency in medication management. RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in Medication Administration (documentation sighted), under the direction and delegation of a RN. The manager monitors to ensure all staff who administer medications have current competencies.   Residents wishing to self-medicate have a signed agreement regarding the residents responsibility to safety. The resident’s GP assesses and documents physical and mental capacity for drug self-administration The resident’s capacity is reviewed daily by medication competent staff. Approval is revoked until it is discussed with the resident’s GP if there are any areas of concern. Medication chart references the resident self-administers. Staff checks with resident each shift that they have taken the medication. Locked storage is provided that is only accessible to resident and authorised staff.  The written authorisation (sighted), signed by the resident’s GP authorises the use of standing orders and identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly and this documentation is sighted.   The 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:** |
| Te Arahina O Arihia Rest Homes menu (sighted) is reviewed by the dietitian (evidence of last review in March 2014) and the menu is adjusted according to the dietitian’s recommendations after discussion with residents at the monthly residents’ meeting. The nutritional requirements are based on the Ministry of Health (MOH) food and nutritional guidelines for older people. The facility has a planned menu that changes seasonally. The facility has access to a dietitian and a process for referral and policies and procedures relating to food and nutrition services that are reviewed at least two yearly (sighted).  The cooks (2) are trained and have ongoing education in food safety which was last attended in March 2014, verified by one of one interview and sighted in records.   There is evidence to support sufficient food is ordered and prepared to meet the resident’s recommended nutritional requirements (cooked meat, chicken or fish and fresh fruit 100gm/day). Between meal snacks are available at all times in the rest home and dementia unit, as sighted and verified by resident, staff and family/whanau interview. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.  There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed; this is sighted and the roster is reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience. All food is ordered by the cook on a weekly basis. There is a list of identified local providers from which all food items are sourced. Fruit and vegetables are ordered depending on need and availability. Meats and fish are ordered as required. When food is delivered it is checked for ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.   A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Dietary profiles are retained in the kitchen.   The ARRC requirements 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:** |
| There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided 31 October 2013. Monthly visits are made by Ecolab representative who reviews kitchen, cleaning and laundry processes.  A visual inspection of the facility provides evidence that protective clothing and equipment, that is appropriate to the risks associated with the waste or hazardous substance being handled, are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks viewed in sluice rooms.   Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Sluice facilities are available for the disposal of waste and hazardous substances.  The District Health Board contract requirement is 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:** |
| Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.   The quality assurance manager (QAM) is responsible for maintenance and is interviewed during this audit. During interview the QAM confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. The QAM states external contractors are used as well to maintain the facility. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed along with current calibration / performance reports for medical equipment. Service provider's documentation and visual inspection evidences a current Building Warrant of Fitness that expires 20 May 2014.  A visual Inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to an adequate standard. The manager during interview advises that there is an ongoing refurbishment programme in place and rooms are upgraded as needed.  The building is a Lockwood design and corridors are narrow in several areas but residents are observed passing each other safely. Equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (eg, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate and secure fencing; and ensuring a safe area is available for recreation or evacuation purposes). There is a range of low stimulus areas in the dementia unit which can be used when required.  Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.  Residents and family interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the facility is homely and the accommodation meets their needs.  The District Health Board contract 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:** |
| Bedrooms provide single and double accommodation and there are an adequate number of toilet and shower facilities available throughout the facility.   Visual inspection provides evidence that toilet, shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at least monthly and is delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).  All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.  The District Health Board contract requirement is 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:** |
| Visual inspection provides evidence that the double bedrooms are small and most are used as single accommodation. Adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of residents, family and staff. Resident’s bedrooms are personalised to varying degrees.   The District Health Board contract 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:** |
| Visual inspection provides evidence that adequate access is provided to lounges, dining rooms, and outside. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. Low stimulus areas are available in the dementia unit. Residents and family members interviewed voiced no concerns regarding the communal dining areas.  The District Health Board contract requirement is 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:** |
| All laundry services are contracted out to a local contractor. The manager reports satisfaction with the service with minimal concerns. Dirty laundry is packed into appropriate laundry bags, stored safely and picked up and returned. Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.  Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed.   Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.  Residents and family interviewed state they are satisfied with the cleaning and laundry service.  The District Health Board contract 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:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting, along with policy/procedures for visitor identification are sighted. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.   New Zealand Fire Service letter dated 1 August 2000 is sighted advising the fire evacuation scheme has been approved. The last trial evacuation was held on the 26 March 2014.  All staff are required to have current first aid certificates. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education.   A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.   A visual inspection of the facility provides evidence that there is a generator for emergency lighting, torches, and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.   There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents and family interviewed confirm they or their relative has a call bell system in place which is accessible and staff generally respond to it in a timely manner.  The District Health Board contract requirements are met. |

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

#### Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Under floor heating provides heating throughout the facility. Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.  The District Health Board contract requirements are met. |

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

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

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

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

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

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are currently three residents using restraint and one resident using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. The restraint coordinator who is the manager/RN states they are actively reducing restraint use, and managing residents by using low beds, and sensor mats, and landing pads – sighted. Challenging behaviour is managed in the dementia unit, and residents were observed to be calm. Staff have received on going challenging behaviour education – this last occurred in November 2013.  The District Health Board contract requirement is met. |

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

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

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that include responsibilities for key staff at an organisational level and the service level and is reviewed during this audit. The restraint co-ordinator is the manager/RN and during interview they are able to describe the role and responsibilities of the position. The restraint co-ordinator's job description was sighted in the manager/RN’s personal file. The restraint approval group meets monthly as part of the staff meetings and minutes are sighted.  The District Health Board contract requirement is met. |

##### 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:** |
| Assessments are completed for residents using restraint as sighted in the residents' files reviewed. Care plans reviewed indicate that the assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family. This finding is confirmed during interview of a resident and family member. The ‘Consent/assessment Form’ documents that the RN, family and GP are involved.  The District Health Board contract 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 assessment form identifies that the key relevant aspects of this standard is included in any assessment of restraint. There is an assessment process and it includes consultation with the resident and family and is reviewed on residents’ files. A restraint register is maintained that records the three residents using restraint and one resident using an enabler (reviewed). Falls risk and challenging behaviour assessments and plans are completed for residents using restraint.   Staff are trained in restraint minimisation – last provided 27 December 2013 and managing challenging behaviour - last provided in November 2013 (training records are sighted).   The residents requiring restraint are monitored at least two hourly when restraint is in use. Other interventions are documented as being used. Monitoring/care forms reviewed provide evidence that residents using restraint are monitored on a regular basis with information recorded on the monitoring/care form.  The District Health Board contract 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:** |
| Restraint evaluation processes are documented in the restraint minimisation and safe practice policy which is reviewed. The residents' files evidence that each episode of restraint is being evaluated at least six monthly, and more often if the resident’s level of risk increases.   Meeting minutes reviewed and interview of the manager indicates that restraint practices are discussed at restraint approval meetings and at quality meetings, and individual residents are also reviewed. Restraint is also reviewed as part of the care plan evaluation as sighted in one resident’s file.  The District Health Board contract 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 restraint coordinator reports the use of any restraint is reviewed at the time of the six-monthly individual resident care plan evaluation as well as monthly at the staff/restraint meeting and quality meetings (minutes sighted for 2013 and 2014). The restraint coordinator reviews and updates the restraint register at least monthly and as any resident is identified as using restraint.  The restraint programme is reviewed monthly as a whole and further training opportunities, changes to policy are considered at these meetings. Care plans related to the use of restraint are also reviewed.  All staff interviewed confirm knowledge of the use of restraint and enablers. They can also describe strategies used to de-escalate behaviour and these were sighted in use on the days of the audit.  The District Health Board contract requirement is 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:** |
| Te Arahina O Arihia Rest Home provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the manager to ensure appropriate resources are available for the effective delivery of the infection control programme and it is her responsibility assisted by the RN to implement the programme.   The infection control practices are guided by the infection control manual and assistance from the Waikato DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Reporting lines are clearly defined. The infection control nurses records monthly infection rate data and present a monthly report to the quality meeting and staff meetings. The manager reports to the organisation’s quality co-ordinator and the Trustees any serious infection related issues. The infection control programme is reviewed annually and was last reviewed in March 2014. |

##### 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 Manager and registered nurse are responsible for infection control at Te Arahina O Arihia Rest Home. A position description is included in the Infection Control (IC) programme and in the RN's file.   The infection control nurses verify there are enough human, physical and information resources to implement the infection control programme. They take responsibility for implementing the infection control programme and have access to expert advice when required. Infection control training of the infection control nurses occurs via training offered through an external provider and in-service training offered by the Care Online service and the Waikato DHB. The infection control nurses have access to records, diagnostic results (I,e information from laboratory and the GP) to ensure timely treatment and resolution of infections.   The infection control nurses facilitate the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. Any IC concerns are reported at the Trust’s Quality Meeting. The IC nurses report to the quality committee and staff meetings any IC issues on monthly basis. IC data is collected monthly and statistics and data is calculated. |

##### 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:** |
| Te Arahina O Arihia Rest Home has an infection control (IC) programme that is reviewed annually, and includes policies and procedures. These cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the manager as current.   Staff interviewed (two of two care staff) are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry and kitchen staff (three of three) are observed to be compliant with generalised infection control practices. A new staff member in the process of orientation, verified training in infection control during orientation. |

##### 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:** |
| Service providers receive orientation and ongoing education on infection control that is relevant to their practice, as verified by education records and ten of ten staff interviews. The content of the infection control education sessions is documented and evaluated to ensure the content is pertinent. A record of attendance is maintained and evidence of this is sighted.  Resident education occurs in a manner that recognises and meets the resident’s communication style, as sighted in the file of a resident with a chest infection and verified by resident interview  There has been no evidence of Norovirus in the last five years. |

##### 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:** |
| In line with the facility's IC policy and procedures, monthly surveillance is occurring at Te Arahina O Arihia Rest Home. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month (as diagnosed by a doctor) are recorded on an infection report form . Incidents of infections are sighted and are low. These are collated each month and analysed to identify any significant trends or possible causative factors. A yearly comparison based on previous incidents are used as a benchmark. Any actions required are implemented. Outcomes are presented to staff at daily handover, staff meetings and quality assurance meetings and the necessary corrective actions discussed. Findings are presented at Trust meetings, with any necessary Trust requirements discussed and actioned.  A quality initiative is in place at Te Arahina O Arihia Rest Home aimed at reducing the number of urinary tract infections. The use of sanitising wipes to clean the toilet after each resident’s use commenced in September 2013. Since implementing this initiative the number of urine infections has decreased from six to one. |

##### 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:** |
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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 3.5.7 (HDS(IPC)S.2008:3.5.7)

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| A quality initiative is in place at Te Arahina O Arihia Rest Home aimed at reducing the number of urinary tract infections. The analysis of infection surveillance data from January to June 2013 noted six urinary tract infections (UTI’s) – four of these in the dementia unit. Despite increased fluid intake, reassessment of incontinence products, management of toileting regimes and numerous other interventions the UTI’s continued. A possible problem of cross infection was identified. A trial use of sanitising wipes to clean the toilet after each resident’s use was commenced in September 2013 and has resulted in only one UTI being recorded in the 6 months following implementation. |
| **Finding:** |
| Implementation of the infection control quality initiative regarding urinary tract infections (UTI’s) has resulted in a decrease of UTI’s. |
| **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.)* |