

# Kerikeri Village Trust

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Current Status: 7 May 2014

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

## General overview

Kerikeri Retirement Village is certified to provide rest home, hospital and dementia level care for up to 67 residents. On the day of the audit there were 25 residents at rest home level care, 23 residents at hospital level care and 15 residents receiving dementia care.

The service is owned by a community trust and managed by a general manager who is a registered nurse with over 20 years' experience in the role. She is supported by a clinical manager. The care services promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required by the service in the following areas; informing families of incidents, including all incidents in quality data analysis, corrective action planning, assessments, care planning, evaluations, wound management, weekly weighs, 24 hour activity plans for dementia residents and aspects of medication management.

## Audit Summary as at 7 May 2014

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 7 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 7 May 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 7 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 7 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 7 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 7 May 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 7 May 2014

### Consumer Rights

Kerikeri Retirement Village's philosophy is to provide a quality service that focuses offering opportunities for older people to enjoy life and foster a sense of belonging in the community. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around informing families of incidents.

### Organisational Management

Kerikeri Retirement Village has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to monthly staff and quality meetings and monthly quality/health and safety meetings. There are improvements required around including all incidents in quality data analysis and corrective action planning. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Kerikeri Retirement Village has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

### Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people

including residents and where appropriate family / Whanau or Enduring Power of Attorney. An assessment, including a variety of risk assessments is intended to be completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. Communication with family is well documented. There are improvements required around assessments, weekly weighs, wound management, care planning and evaluations.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. There is an improvement required around documenting activities over the 24 hour period for dementia residents.

Medicine management policies and procedures detail service provider's responsibilities. Registered nurses, an enrolled nurse and the senior caregivers are responsible for medicine management have attended in-service education for medication management. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around administration documentation, as required medication prescribing, dating eye drops when opened, transcribing, staff competency assessments and review of competency assessments for residents who self-administer medicines.

The service has transfer and discharge procedures the staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

### **Safe and Appropriate Environment**

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is taken off site. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

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

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the

definition in the standards. There is a restraint register and enablers register. There are eight residents requiring restraints and six residents with identified enablers. Restraint assessments are based on information in the care plan, discussions with residents/relatives and on staff observations of residents. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Restraint is reviewed for each individual at least six monthly and as part of the multidisciplinary review. Multidisciplinary reviews include family/whanau. Staff are trained in restraint minimisation and challenging behaviour.

### **Infection Prevention and Control**

The infection control coordinator is a registered nurse and acts as the clinical manager two days per week. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually by the facilities infection control committee. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Kerikeri Village Trust		
<b>Certificate name:</b>	Kerikeri Village Trust		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Kerikeri Village		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care; Dementia care		
<b>Dates of audit:</b>	<b>Start date:</b> 7 May 2014	<b>End date:</b> 8 May 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			63

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	7
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	7
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	28	Total audit hours off site	16	Total audit hours	44
Number of residents interviewed	9	Number of staff interviewed	16	Number of managers interviewed	4
Number of residents' records reviewed	7	Number of staff records reviewed	11	Total number of managers (headcount)	4
Number of medication records reviewed	18	Total number of staff (headcount)	101	Number of relatives interviewed	9
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Friday, 6 June 2014

## Executive Summary of Audit

### General Overview

Kerikeri Retirement Village is certified to provide rest home, hospital and dementia level care for up to 67 residents. On the day of the audit there were 25 residents at rest home level care, 23 residents at hospital level care and 15 residents receiving dementia care. The service is owned by a community trust and managed by a general manager who is a registered nurse with over 20 years' experience in the role. She is supported by a clinical manager. The care services promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided. This audit identified improvements required by the service in the following areas; informing families of incidents, including all incidents in quality data analysis, corrective action planning, assessments, care planning, evaluations, wound management, weekly weighs, 24 hour activity plans for dementia residents and aspects of medication management.

### Outcome 1.1: Consumer Rights

Kerikeri Retirement Village's philosophy is to provide a quality service that focuses offering opportunities for older people to enjoy life and foster a sense of belonging in the community. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around informing families of incidents.

### Outcome 1.2: Organisational Management

Kerikeri Retirement Village has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to monthly staff and quality meetings and monthly quality/health and safety meetings. There are improvements required around including all incidents in quality data analysis and corrective action planning. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Kerikeri Retirement Village has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

### Outcome 1.3: Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / Whanau or Enduring Power of Attorney. An assessment, including a variety of risk assessments is intended to be completed on

admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. Communication with family is well documented. There are improvements required around assessments, weekly weighs, wound management, care planning and evaluations. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. There is an improvement required around documenting activities over the 24 hour period for dementia residents.

Medicine management policies and procedures detail service provider's responsibilities. Registered nurses, an enrolled nurse and the senior caregivers are responsible for medicine management have attended in-service education for medication management. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around administration documentation, as required medication prescribing, dating eye drops when opened, transcribing, staff competency assessments and review of competency assessments for residents who self-administer medicines.

The service has transfer and discharge procedures The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

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

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There is large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is taken off site. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

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

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and enablers register. There are eight residents requiring restraints and six residents with identified enablers. Restraint assessments are based on information in the care plan, discussions with residents/relatives and on staff observations of residents. Staff are trained in restraint minimisation and restraint competencies are completed regularly. Restraint is reviewed for each individual at least six monthly and as part of the multidisciplinary review. Multidisciplinary reviews include family/whanau. Staff are trained in restraint minimisation and challenging behaviour.

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

The infection control coordinator is a registered nurse and acts as the clinical manager two days per week. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually by the facilities infection control committee.

Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	42	0	4	4	0	0
<b>Criteria</b>	0	90	0	7	4	0	0

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

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Six of ten incident forms reviewed did not show documented evidence that family were informed following the incident.	Ensure that all family are informed following a resident's incident.	180
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are	PA Low	Three documented	Ensure that all documented	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		wounds (two skin tears and one pressure area) that are documented on wound incident forms were not evidenced as part of the data analysis in the quality meetings.	incidents are included in the quality data analysis.	
HDS(C)S.2008	Criterion 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.	PA Low	Corrective action reports following audits do not show documented evidence of planning, outcomes and resolution in some audits.	Ensure that all corrective action reports following audits show documented evidence of planning, outcomes and resolution.	90
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	(i) One respite resident (from the rest home) has not had the assessment reviewed for this admission and one hospital resident who had previously been admitted for respite did not have the assessment reviewed when she was admitted for long term care. (ii) Four of the five Maori residents had not had a cultural assessment completed. (iii) Risk assessments have not been reviewed six monthly for two of eight resident files sampled (one rest home and one hospital). (iv) Pain assessment was not evidenced as	(i) Ensure an admission assessment is completed/updated for each admission. (ii) Ensure all Maori residents have a cultural assessment. (iii) Ensure all risk assessments are reviewed at least six monthly. (iv) Ensure pain assessments are completed for all residents and on-going pain monitoring is completed for residents with on-going pain.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				completed with on-going monitoring recorded for one hospital resident requiring administration of controlled medication as part of prescribed pain management plan. This resident and one other resident with on-going pain do not have on-going pain monitoring.		
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Six of eight care plans (two from the dementia unit, two from the hospital and two from the rest home) do not include interventions relating to all identified areas of need. Examples include Maori culture, pressure risk, twice weekly blood pressures, weekly weighs and hip protectors). One dementia resident does not have a fully completed care plan.	Ensure all residents have a fully completed care plan that includes interventions for all identified areas of need.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	(i) One resident is documented as requiring a weekly weigh and this is not occurring. (ii) Wound management is	(i)Ensure weekly weighs are completed when these are required. (ii) (a) Ensure all pressure areas have a grade documented. (ii) Ensure all	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				an area requiring improvement: (a) Two pressure areas do not have a grade documented. (b) One resident has a skin tear that is documented on an incident form but there is no wound assessment or management plan. (c) Sixteen of the 23 wounds have not been reviewed within the stated timeframe.	wounds have a documented assessment and plan (iii) Ensure all wounds are reviewed within stated timeframes.	
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Residents in the dementia unit do not have a plan to cover the 24 hour period.	Ensure that residents in the dementia unit have an activities plan to cover the 24 hour period.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.2	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.	PA Low	Two of eight files sampled (one from the hospital and one from the dementia unit) have not had the care plan evaluated in the past six months.	Ensure all care plans are evaluated six monthly.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe and timely manner that	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	complies with current legislative requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i) Seven of 16 medication administration signing sheets have regular medications that have not been signed as administered. (ii) Two of 16 medication charts have medications that have been administered more regularly than prescribed (eye drops). (iii) Twelve of 16 medication charts had PRN medications charted with no indication for use. (iv) There is transcribing on the medication prompt sheets in the rest home medication folder. (v) There are two eye drops that have not been dated when opened in the dementia unit.	(i) and (ii) /ensure medications are administered as prescribed. (iii) Ensure PRN medication prescriptions document an indication for use. (iv) Cease the practice of transcribing. (v) Ensure all eye drops are dated when opened.	90
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	Eleven of 19 registered nurses and the one enrolled nurse have not been assessed as competent in the past year.	Ensure all staff who administers medications have a regular competency assessment.	90
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	One of the three residents who self-administer medicines has not had a competency assessment review since November 2013.	Ensure medication competencies are completed at least three monthly.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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There is a code of rights policy. On interview all staff (six caregivers (three rest home/dementia and three hospital), one enrolled nurse (rest home/hospital), three registered nurses (RN's), one clinical manager, one infection control coordinator (RN and clinical manager two days per week), one quality improvement and OSH coordinator (RN), and one manager (RN), were aware of consumers rights and were able to describe how they incorporated consumer rights within their service delivery. Code of Rights is discussed at monthly resident and monthly staff meetings. Nine of nine residents (four rest home and five hospital) and nine of nine family members (one rest home, five hospital and three dementia), interviewed spoke highly of the staffs respect of all aspects of the code of rights. Code of rights training, advocacy and informed consent is part of the staff in-service training day held in February and April 2014.
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### Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<b>Finding:</b>
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<b>Corrective Action:</b>
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<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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## Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (six caregivers, one enrolled nurse, three RN's, one clinical manager, one infection control coordinator (RN) and one quality improvement and OSH coordinator (RN) stated that they take time to explain the rights to residents and their family members. Nine residents (four rest home and five hospital), and nine family members (one rest home, five hospital and three dementia), confirmed that they had received information about their rights on entry to the service.

The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the clinical manager or an RN discuss the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy. On interview nine of nine residents and nine of nine family members were able to state their understanding of the code of rights.

Health and disability advocacy service leaflets are on display on the notice board in the foyer and throughout the facility. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested. Education on advocacy services is provided in the facilities self-directed induction learning package and at in-service training days.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All nine residents and nine family members interviewed indicated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training is part of the facilities self-directed induction learning package and in-service training days.</p> <p>The resident's initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All nine residents interviewed stated their needs were met. All eight resident files reviewed (three rest home, three hospital and two dementia unit), have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.</p> <p>There is a policy that describes resident's spiritual care. There are various churches locally and residents are encouraged to attend these. Multidenominational services are conducted in the facility at least once a week on Sundays. The service employs a Chaplain for four hours per week who acts as the residents advocate and runs the residents meetings. The Chaplain links with the Bay of Island Chaplain Service. All residents and family members interviewed indicated that resident's spiritual needs are being met when required. On interview all nine residents (four rest home and five hospital), stated staff respect their rights. The service includes emotional wellbeing in the care planning process.</p> <p>Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered and discussed openly. On interview all nine residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all six caregivers described how they encouraged residents to engage in activities in the facility and to link with community activities including church and support groups.</p> <p>There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff in-service training days held in February and April 2014. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Discussions with staff identified that there have been no episodes of abuse or neglect at the facility. Nine residents and nine family members interviewed were complementary of the care</p>

provided and stated staff were very approachable and friendly.

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

E4.1a: Three of three families from the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a: Resident files reviewed identified that cultural, spiritual values and individual preferences are identified.

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

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

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

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

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

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

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

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

**Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.  Staff training includes cultural safety at orientation. There are presently five residents who identify as Maori. Cultural assessments have not been completed for four of</p>

these five residents to reflect cultural preferences (link 1.3.4.2). Kerikeri Retirement Village identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review (link 1.3.5.2). This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the RN's, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with three RN's, one enrolled nurse (EN), one clinical manger, one infection control coordinator (RN), one quality improvement and OSH coordinator, six caregivers and one manager (RN) confirm that they are aware of the need to respond to cultural differences . On interview all staff were able to identify how to obtain support so that they could respond appropriately.

A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).

D20.1i: The service has developed a link with local Maori organisations and iwi.

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. There is one resident from another culture and the daughter of the resident has given staff a number of sentences to use to communicate with the resident and the staff have learnt these.</p> <p>Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.</p> <p>D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs  D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>

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

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

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

**Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The facility has a policy that determines a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of code of rights training and includes professionalism and standards of conduct. The RN's supervises staff to ensure professional practice is maintained in the service.          Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>

**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.

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

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete Aged Care Education programme NZQA level training and an internal in-service training programme is implemented. The manager and clinical managers attend external training sessions appropriate for their positions.

A2.2: Services are provided at the facility that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3: All approved service standards are adhered to.

D17.7c: There are implemented competencies for RN's and EN's. There are clear ethical and professional standards and boundaries within job descriptions

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

### Evidence:

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Ten incidents/accidents forms were viewed for January, February, March and April 2013. The forms include a section to record family notification. Four forms reviewed indicated family were informed or if family did not wish to be informed. This is an area requiring improvement. Kerikeri Retirement Village has an open disclosure policy. On interview nine residents (four rest home and five hospital), nine family members (one rest home, five hospital and three dementia), one enrolled nurse and six caregivers (one rest home/hospital, one dementia, one dementia/hospital and three hospital) all stated that family are informed following changes in the resident's health status.

Three two registered nurses interviewed stated that they record contact with family/whanau in residents files. Contact records were documented in all nine resident files reviewed.

Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. Family are encouraged to assist with communication where appropriate (link 1.1.6).

A residents meeting occurs two monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.

There is a policy that describes the availability of interpreter services when required.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Nine of nine family members interviewed stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

**Attainment and Risk:** PA Low

### Evidence:

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available

### Finding:

Six of ten incident forms reviewed did not show documented evidence that family were informed following the incident.

### Corrective Action:

Ensure that all family are informed following a resident's incident.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for seven of seven files sampled (three from the rest home, two from the dementia unit and three from the hospital). Seven files were reviewed and found to have valid consents. It was stated by the registered nurses that family involvement occurs with the consent of the resident. Other forms of written consent included consent to share information, consent for photographs and consent for transportation. A review of seven files found all consents were present and signed by the resident or their enduring power of attorney (EPOA). EPOA documents are kept on the resident's file. Nine residents interviewed (five from the hospital and four from the rest home) confirm that they are given good information to be able to make informed choices. Six caregivers and three registered nurses interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.</p> <p>D13.1 There were seven of seven admission agreements sighted.</p> <p>D3.1.d Discussion with nine families (one from the rest home, three from the dementia unit and five from the hospital) identified that the service actively involves them in decisions that affect their relative's lives.</p>

**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.

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

**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained where required.

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

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

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

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

**Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an advocacy policy. Staff receive training on advocacy services. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with six caregivers, nine residents and nine family members informed they are aware of advocacy and how to access an advocate. There is a Chaplain employed by the service who also acts as he residents advocate and runs the residents meetings two monthly.</p> <p>D4.1d: Discussion with nine family members (one rest home, five hospital and three dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions. There is a round table meeting held six monthly for each resident with family involvement.</p> <p>D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks.</p>

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (six caregivers, one enrolled nurse, three registered nurses, one clinical manager, one infection control coordinator (RN), one quality improvement OSH (RN) and the manager (RN), stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. The facility engages with other local facilities that provide similar services.

D3.1h; Discussion with nine family members stated that they are encouraged to be involved with the service and care.

D3.1.e: Discussion with all staff (six health caregivers, one enrolled nurse, three registered nurses, one clinical manager, one infection control coordinator (RN), one quality improvement OSH (RN) and the manager (RN), and nine family members (one rest home, five hospital and three dementia), confirm that they are supported and encouraged to remain involved in the community and external groups such as church.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

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

**Attainment and Risk:** FA

**Evidence:**

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

**Standard 1.1.13: 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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about the complaints process is provided on admission. Interview with nine residents (four rest home and five hospital) and nine family members (one rest home, five hospital and three dementia), inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints</p> <p>There is a complaints register. The service had only received two complaints. One in 2013 regarding meal quality which was resolved. One complaint just received in May 2014 from the Northland District Health Board from a daughter of a resident regarding the quality of care provided to her mother by a number of health care providers, Kerikeri is one of the providers named. This is currently being investigated and a response is to be forward to the Northland District Health Board by 12 May 2014. Verbal and written complaints are documented when received. All complaints are recorded in the complaints register. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.</p> <p>Discussions with nine residents and nine family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with six caregivers stated that concerns/complaints would be discussed at monthly staff meetings.</p> <p>D13.3h: A complaints procedure is provided to residents within the information pack at entry.</p> <p>E4.1biii: There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> <li>1. Minimising restraint.</li> <li>2. Behaviour management.</li> <li>3. Complaint policy.</li> </ol>

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

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

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

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

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

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

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

## Outcome 1.2: Organisational Management

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Kerikeri Retirement Village (also known as Kerikeri Village Trust) was founded in 1983 as a non-profit community venture between Presbyterian Support Services (Northern), the Murray-Graveson Trust and the Auckland Methodist Mission. It is a purpose built facility. Kerikeri retirement village is run by Kerikeri Village Trust in partnership with family, friends and community services to help residents. The facility is owned by a community charitable trust. Governance is undertaken by a board of trustees. A local GP interfaces with the board in an advisory capacity. Currently there are seven board members (four are the trustees that own the business). The manager reports to the board at monthly meetings. One of the trustees attends the resident's two monthly meetings providing residents with direct contact to the board.</p>

The service can provide care for 67 residents. On the day of the audit there were 63 residents (25 rest home, 23 hospital and 15 dementia).

Kerikeri Retirement Village is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were two residents under this category of care.

Kerikeri Retirement Village has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The current business plan service goals include but not limited to: a) build and develop relationships with key local health services and experts in New Zealand, b) bringing the community into the facility, c) staff support and retention, d) growth of the service. The service mission states; "Kerikeri retirement village will provide quality service to older people and their families/whanau. The trust will offer opportunities for older people to enjoy life and foster a sense of belonging in the community". Core values include: family/whanau, community, deeply caring, enormously respectful and staff are family.

The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Monthly staff meetings monthly quality meetings discuss key components of the quality system including bench marking and any issues are reported (minutes viewed). There is an internal audit schedule that aligns with the business plan and is implemented and a corrective action plan used to manage shortfalls. The manager is a registered nurse and has been employed at the service for 23 years. The manager is suitably qualified with years of experience including human resource management. The manager maintains her practicing certificate attending clinical updates. The manager has also attended conferences including, New Zealand retirement village conference, New Zealand aged care conference and New Zealand management conference. The manager is supported by the clinical manager who has been employed at the service for 11 years and another registered nurse that has been at the service for six years and acts as the clinical manager two days per week and is also the infection control coordinator.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  In the absence of the manager the clinical manager oversees the management of Kerikeri Retirement Village. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

The facility has a quality framework that is being implemented. The manager is directly involved in operations at the facility and the clinical manager, infection control coordinator (RN and clinical manager two days per week) and quality improvement and OSH coordinator (RN) support the manager in this role. The service has employed an external consultant to assist in reviewing the quality and risk programme. There is a current business plan that includes objectives/goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (six caregivers, one enrolled nurse, three registered nurses, one clinical manager, one infection control coordinator (RN) and one quality improvement OSH (RN) and the manager, inform an understanding of the quality activities undertaken at Kerikeri Retirement Village. Resident meetings occur two monthly (minutes viewed). Nine of nine residents interviewed are aware meetings are held. Annual satisfaction surveys are undertaken. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.

D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans.

D10.1: Following the death of a resident policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The manager and the senior management team manage quality systems. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff meetings and quality meetings. Meetings discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. The service benchmarks data with other providers (nationwide benchmarking and benchmarking with the local cluster group).

Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked cupboard.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Kerikeri Retirement Village has eight residents with restraints and six residents using nine enablers.

There is a 2014 internal audit programme which includes (but not limited to); kitchen (Jan), client satisfaction (Feb), work place safety (Mar), furniture and equipment cleanliness (Mar), practicing certificates (Mar) and hand-washing (Apr). The 2013 audit programme was also reviewed. Not all issues identified in the 2013 and 2014 audits have identified corrective action plans and resolutions. This is an area requiring improvement. Results of audits are discussed in quality and staff meetings. Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to quality and staff meetings. Three documented wounds (two skin tears and a pressure area) were not evidenced as part of the data analysis. This is an area requiring improvement. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvements have been regularly completed and documented in the quality/staff meeting minutes. All staff interviewed could describe the corrective action process. The facilities

monitoring activities, link to the means of achieving objectives as outlined in the quality programme.

Kerikeri Retirement Village has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Six caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

**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.

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

**Criterion 1.2.3.3 (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.

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

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

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

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

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

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

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

**Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to quality and staff meetings.

<b>Finding:</b> Three documented wounds (two skin tears and one pressure area) that are documented on wound incident forms were not evidenced as part of the data analysis in the quality meetings.
<b>Corrective Action:</b> Ensure that all documented incidents are included in the quality data analysis.
<b>Timeframe (days):</b> 90 (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.

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is a 2014 internal audit programme which includes (but not limited to); kitchen (Jan), client satisfaction (Feb), work place safety (Mar), furniture and equipment cleanliness (Mar), practicing certificates (Mar) and hand-washing (Apr). Results of audits are discussed in quality and staff meetings. Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is reported through to quality and staff meetings.
<b>Finding:</b> Corrective action reports following audits do not show documented evidence of planning, outcomes and resolution in some audits.
<b>Corrective Action:</b> Ensure that all corrective action reports following audits show documented evidence of planning, outcomes and resolution.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

### Standard 1.2.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system (link 1.2.3.6). Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the manager and clinical manager, who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and quality meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. A sample of 10 incidents/accidents from January to April 2014 were viewed. The facilities policy and procedure on incident management were implemented. D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>

#### 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.

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of RN's and EN's are current. The service also maintains copies of other visiting practitioner's certification including

GP, pharmacist and physiotherapist. Appointment documentation is seen in 11 staff files sampled (three RNs, one enrolled nurse, one clinical manager, three caregivers, two cooks, and one DT) including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in all files reviewed.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with six caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. The staff educator (RN) is accountable for managing and delivering the training schedule. Interview with six caregivers inform there is access to sufficient training. Medication competencies are required to be completed for all RN's and staff who administer medication (# link 1.3.12.3).

D17.7d: There are implemented competencies for RN's and EN's related to specialised procedure or treatment including (but not limited to); medication and syringe driver use.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5f There are 14 caregivers who work in the dementia unit. Thirteen of these caregivers have completed ACE dementia standards and one caregiver is trained in mental health.

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

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

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

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

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

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical manager or the manager will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical manager covers the manager during absences and holidays. Residents and relatives interviewed stated they felt there are sufficient staff to meet the needs of residents.

There is an RN on duty 24 hours per day.

A contractor physio attends the facility for 30 hours a week.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of

admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate). All resident files are hard copy files. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home, hospital and dementia service level setting. The service keeps a resident register. Kerikeri Retirement Village has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses' stations in a secured cabinet. Old files are individually archived and locked in a secure area for 10 years. Resident records are up to date and reflect residents' current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible, signed and dated by the staff member recording the information. Medical notes and allied health input are signed and dated appropriately. D7.1: Entries are legible, dated and signed by an RN, EN or caregivers, including designation.

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

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

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

**Criterion 1.2.9.7 (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.

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

**Corrective Action:**

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

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

### Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry to Kerikeri Retirement Village potential residents have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Two resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The admission policy describes the declined entry to services process. Kerikeri Retirement Village records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.2, 3, 4: The eight resident files reviewed (three from the rest home, two from the dementia unit and three from the hospital) identified that an initial nursing assessment (link 1.3.4.2) and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced

evaluations completed at least six monthly (link 1.3.8.2). Activity assessments and the activities sections in care plans have been completed by the diversional therapists. Nine residents interviewed (five from the hospital and four from the rest home) interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed in all resident files sampled.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review were evidenced as occurring on review of residents files with acute conditions. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Seven files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents' health status and she believes the service provided meets resident's needs.

Tracer Methodology rest home:

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

Tracer methodology hospital:

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

Tracer methodology dementia:

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

*One 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.

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

### Criterion 1.3.3.3 (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.

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

### Criterion 1.3.3.4 (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.

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

### Standard 1.3.4: 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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. However one respite resident (from the rest home) has not had the assessment reviewed for this admission and one hospital resident who had previously been admitted for respite did not have the assessment reviewed when she was admitted for long term care. This is an area requiring improvement. Personal needs information is gathered during admission. However only

one of the five Maori residents had a cultural assessment completed. This is also an area requiring improvement. The data gathered is then used to plan resident goals and outcomes (see CAR 1.3.5.2). This includes spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed six monthly for six of eight resident files sampled. This is a further area requiring improvement. Pain assessment was not evidenced as completed with on-going monitoring recorded for one hospital resident requiring administration of controlled medication as part of prescribed pain management plan. This resident and one other resident with on-going pain do not have on-going pain monitoring. This is an area requiring improvement. Nine family (one from the rest home, three from the dementia unit and five from the hospital) and nine residents interviewed (five from the hospital and four from the rest home) interviewed are very satisfied with the support provided.

ARC E4.2: Two resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4, 2a Challenging behaviours assessments are completed.

**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.

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes (see CAR 1.3.5.2). This includes spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed six monthly for six of eight resident files sampled. Nine family (one from the rest home, three from the dementia unit and five from the hospital) and nine residents interviewed (five from the hospital and four from the rest home) interviewed are very satisfied with the support provided.</p>
<p><b>Finding:</b></p> <p>(i) One respite resident (from the rest home) has not had the assessment reviewed for this admission and one hospital resident who had previously been admitted for respite did not have the assessment reviewed when she was admitted for long term care. (ii) Four of the five Maori residents had not had a cultural assessment completed. (iii) Risk assessments have not been reviewed six monthly for two of eight resident files sampled (one rest home and one hospital). (iv) Pain assessment was not evidenced as completed with on-going monitoring recorded for one hospital resident requiring administration of controlled medication as part of prescribed pain management plan. This resident and one other resident with on-going pain do not have on-going pain monitoring.</p>
<p><b>Corrective Action:</b></p> <p>(i) Ensure an admission assessment is completed/updated for each admission. (ii) Ensure all Maori residents have a cultural assessment. (iii) Ensure all risk assessments are reviewed at least six monthly. (iv) Ensure pain assessments are completed for all residents and on-going pain monitoring is completed for residents with on-going pain.</p>
<p><b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The sample of files reviewed included; three hospital residents; two dementia residents; three rest home residents.

A review of the eight resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Two of eight are current and include interventions relating to all identified areas of need. One dementia resident does not have a fully completed care plan. This is an area requiring improvement. There is evidence of six monthly reviews which is signed by a registered nurse (link 1.3.81).

The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist.

E4.3 Two resident files reviewed from the dementia unit identified current abilities, level of independence and specific behavioural management strategies.

D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.

All nine resident files reviewed identified that family were involved. Family contact sheets located at the front of residents' files demonstrated communication with family/EPOA.

D16.3k: Short term care plans are in use for changes in health status.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The sample of files reviewed included; three hospital residents; two dementia residents; three rest home residents.

A review of the eight resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Two of eight are current and include interventions relating to all identified areas of need.

**Finding:**

Six of eight care plans (two from the dementia unit, two from the hospital and two from the rest home) do not include interventions relating to all identified areas of need. Examples include Maori culture, pressure risk, twice weekly blood pressures, weekly weighs and hip protectors). One dementia resident does not have a fully completed care plan.

**Corrective Action:**

Ensure all residents have a fully completed care plan that includes interventions for all identified areas of need.

**Timeframe (days):** 90 (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.

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

### Standard 1.3.6: 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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>Eight resident files were reviewed (three from the rest home, two from the dementia unit and three from the hospital). Six identified that an initial nursing assessment and care plan was completed within 24 hours (link 1.3.4.2) and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced evaluations completed at least six monthly (link 1.3.8.2). Activity assessments and the activities sections in care plans have been completed by the diversional therapists (link 1.3.7.1). The care being provided is consistent with the needs of residents for seven of eight files sampled. One resident is documented as requiring a weekly weigh and this is not occurring. This is an area requiring improvement. Good care is evidenced by discussions with residents, families, caregivers, and registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of at least three monthly medical reviews. The staff educator is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by registered nurse or registered nurses in the progress notes at least daily in all three units (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arrange a GP visit or a specialist referral. The six caregivers (three who work in the dementia unit and rest home and three who work in the hospital), and three registered nurses and the infection control coordinator (an RN), the clinical manager and the general manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Nine residents interviewed (five from the hospital and four from the rest home) and nine family (one from the rest home, three from the dementia unit and five from the hospital) interviewed were complimentary of care received at the facility.</p> <p>D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for 23 wounds including four pressure areas. Two pressure areas do not have a grade documented. One resident has a skin tear that is documented on an incident form but there is no wound assessment or management plan. Sixteen of the 23 wounds have not been reviewed within the stated timeframe. Wound management is an area requiring improvement.</p> <p>The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are</p>

available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Eight resident files were reviewed (three from the rest home, two from the dementia unit and three from the hospital). Six identified that an initial nursing assessment and care plan was completed within 24 hours (link 1.3.4.2) and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of eight care plans evidenced evaluations completed at least six monthly (link 1.3.8.2). Activity assessments and the activities sections in care plans have been completed by the diversional therapists (link 1.3.7.1). The care being provided is consistent with the needs of residents for seven of eight files sampled. Good care is evidenced by discussions with residents, families, caregivers, and registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of at least three monthly medical reviews. The staff educator is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by registered nurse or registered nurses in the progress notes at least daily in all three units (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The six caregivers (three who work in the dementia unit and rest home and three who work in the hospital), and three registered nurses and the infection control coordinator (an RN), the clinical manager and the general manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Nine residents interviewed (five from the hospital and four from the rest home) and nine family (one from the rest home, three from the dementia unit and five from the hospital) interviewed were complimentary of care received at the facility. D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for 23 wounds including four pressure areas. The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

**Finding:**

(i) One resident is documented as requiring a weekly weigh and this is not occurring. (ii) Wound management is an area requiring improvement: (a) Two pressure areas do not have a grade documented. (b) One resident has a skin tear that is documented on an incident form but there is no wound assessment or management plan. (c) Sixteen of the 23 wounds have not been reviewed within the stated timeframe.

**Corrective Action:**

(i) Ensure weekly weighs are completed when these are required. (ii) (a) Ensure all pressure areas have a grade documented. (ii) Ensure all wounds have a documented assessment and plan (iii) Ensure all wounds are reviewed within stated timeframes.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are five activities coordinators and a diversional therapist at Kerikeri Retirement Village who work a combined total of 32 hours per week who are responsible for the planning and working with 70 volunteers in the delivery of the activities programme. There is a separate programme for the dementia unit and the rest home and hospital. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. Residents in the dementia unit do not have a plan to cover the 24 hour period and this is an area requiring improvement.

The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Kerikeri Retirement Village has its own van for transportation. Residents interviewed described attending concerts, school music productions, going shopping, lunches and picnics, and shopping. The van drivers have a current first aid certificate.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are five activities coordinators and a diversional therapist at Kerikeri Retirement Village who work a combined total of 32 hours per week who are responsible for the planning and working with 70 volunteers in the delivery of the activities programme. There is a separate programme for the dementia unit and the rest home and hospital. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Kerikeri Retirement Village has its own van for transportation. Residents interviewed described attending concerts, school music productions, going shopping, lunches and picnics, and shopping. The van drivers have a current first aid certificate.

**Finding:**

Residents in the dementia unit do not have a plan to cover the 24 hour period.

**Corrective Action:**

Ensure that residents in the dementia unit have an activities plan to cover the 24 hour period.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is at least a three monthly review by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six of eight care plans sampled. This is an area requiring improvement. There are short term care plans (STCPs) to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. One STCP reviewed evidenced transition into the long term care plan. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is at least a three monthly review by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six of eight care plans sampled. There are short term care plans to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved.

**Finding:**

Two of eight files sampled (one from the hospital and one from the dementia unit) have not had the care plan evaluated in the past six months.

**Corrective Action:**

Ensure all care plans are evaluated six monthly.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, speech language therapist, occupational therapist and wound care nurse.

D16.4c: The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.

D 20.1; Discussions with the registered nurses and clinical nurse leaders identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, occupational therapist and physiotherapist.

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

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

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

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

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

ARC D21 ARHSS D21

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.          Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.</p>

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

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

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

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital and rest home and in a locked trolley in the dementia unit. Controlled drugs are stored in a locked safe in the hospital and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.

There are two eye drops that have not been dated when opened in the dementia unit.

Staff sign for the administration of medications on medication signing sheet. Seven of 16 medication administration signing sheets have regular medications that have not been signed as administered. Two of 16 medication charts have medications that have been administered more regularly than prescribed (eye drops). Twelve of 16 medication charts had PRN medications charted with no indication for use. There is transcribing on the medication prompt sheets in the rest home medication folder. These are areas requiring improvements. The medication folder includes a list of specimen signatures.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.

Education on medication management occurred 2013. Registered nurses, the one enrolled nurse and senior caregivers administer medicines. Eleven of 19 registered nurses and the one enrolled nurse have not been assessed as competent in the past year. This is also an area requiring improvement.

There are appropriate policies around residents who self-administer medicines. There are three residents who self-administer medicines in the rest home. All have a safe place to store their medicines. One of the three residents who self-administer medicines has not had a competency assessment review since November 2013. This is an area requiring improvement.

D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital and rest home and in a locked trolley in the dementia unit. Controlled drugs are stored in a locked safe in the hospital and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.

There are two eye drops that have not been dated when opened in the dementia unit.  
Staff sign for the administration of medications on medication signing sheet.

**Finding:**

(i) Seven of 16 medication administration signing sheets have regular medications that have not been signed as administered. (ii) Two of 16 medication charts have medications that have been administered more regularly than prescribed (eye drops). (iii) Twelve of 16 medication charts had PRN medications charted with no indication for use. (iv) There is transcribing on the medication prompt sheets in the rest home medication folder. (v) There are two eye drops that have not been dated when opened in the dementia unit.

**Corrective Action:**

(i) and (ii) /ensure medications are administered as prescribed. (iii) Ensure PRN medication prescriptions document an indication for use. (iv) Cease the practice of transcribing. (v) Ensure all eye drops are dated when opened.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Education on medication management occurred 2013. Registered nurses, the one enrolled nurse and senior caregivers administer medicines.

**Finding:**

Eleven of 19 registered nurses and the one enrolled nurse have not been assessed as competent in the past year.

**Corrective Action:**

Ensure all staff who administers medications have a regular competency assessment.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are appropriate policies around residents who self-administer medicines. There are three residents who self-administer medicines in the rest home. All have a safe place to store their medicines.

**Finding:**

One of the three residents who self-administer medicines has not had a competency assessment review since November 2013.

**Corrective Action:**

Ensure medication competencies are completed at least three monthly.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Kerikeri Retirement Village has a commercial kitchen and all food is cooked on site. There is a household manager, two cooks, three tea cooks and two kitchen hands. All have food safety training. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in May 2013. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review (see CAR 1.3.4.2). Changes to residents' dietary needs are communicated to the kitchen as reported by the household manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include pureed diets, soft diets, vegetarian and diabetic diets. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule which is signed by member of staff completing cleaning tasks.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.

D19.2 Staff have been trained in safe food handling.

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

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

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

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

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

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

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

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

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

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

## Outcome 1.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards.

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

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

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Reactive and preventative maintenance occurs. There is a maintenance person who works 40 hours per week and is supported by the village maintenance person who also works 40 hours per week. They share on call. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires 31 August 2014. Electrical equipment is checked. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.

Hoists are serviced annually and this last occurred in September 2013. Medical equipment was last calibrated in May 2014.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c: There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

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

**Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

**Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

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

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

The service has single rooms. Most rooms have either an ensuite or a separate shower and toilet between two rooms. There are also communal toilets and showers close to bedrooms. Toilets are located close to dining rooms and lounges for residents' use. A visitor's toilet is available. Water temperatures are tested monthly by the maintenance person and records show they are within safe limits. Residents and caregivers interviewed report there are sufficient toilets and showers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Observation on day of audit demonstrated walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with caregivers. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists. Residents interviewed are very happy with their rooms.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are several lounges and dining areas in each area. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required. Lounge spaces are adequate to cater for the potential extra hospital level residents being approved in this audit.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

**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.

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

**Standard 1.4.6: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> All laundry is completed on site by dedicated laundry staff. Chemicals are stored in a locked room in each area. All chemicals are labelled with manufacturer's labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audit occurred in 2013 attaining 100%.

**Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)**

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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

**Corrective Action:**

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

**Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training at the staff in-service days held in February and April 2014. A fire drill was held in November 2013. Emergency equipment is available. Civil defence supplies are available in a large cupboard and is well equipped (sighted). The staff stated that they have spare blankets and alternative cooking methods if required. There is sufficient water stored to ensure for three litres per day for three days per resident. The staffing level provided adequate numbers of staff to facilitate safe care to rest home, dementia and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 12 April 2005. There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available and /or on call to all residents 24 hours per day, seven days per week. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility has heating in hallways, bedrooms and communal areas. The temperature can be adjusted to suit individual resident temperature preference. Rooms are well ventilated and windows provide natural light. Facility temperatures are monitored. Nine residents interviewed stated the temperature of the facility was comfortable.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<p>There is a restraint policy and manual with associated procedures and templates. The policy states that the use of restraints is kept to a minimum and that care staff who may be involved in restraint and enabler use have sufficient knowledge and skill to be able to ensure resident safety.</p>
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<p>The restraint policy and procedure includes definitions such as use of restraint, types of restraint permitted, use of enablers, enablers permitted, client rights, assessment, discussion, restraint alternatives, monitoring and removal. There is a restraint/enabler assessment form, consent form and monitoring form. Kerikeri Retirement Village has eight residents with restraints (bedrails, lap belts and chair supports) in the hospital. The restraint policy requires that the service considers alternatives to restraint prior to any intervention. The policy also includes procedures for the use of restraint, cultural considerations, guidelines for restraint use and monitoring. On-going consultation with the resident and family/whanau is also identified.</p>
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<p>The service identifies enablers as items which are voluntarily used for safety. There are six residents who use a total of nine enablers (four lap belts and five bed rails).</p>
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<p>The restraints policy defines enablers as being voluntary use of equipment e.g. for safety for the resident. Restraint minimisation training and challenging behaviour was last delivered in February and April 2014 as part of the staff in-service training day and 18 staff attended. Restraint minimisation and challenging behaviour is also presented in a work book for all staff to complete. All six caregivers interviewed could describe processes around enabler, restraint and challenging behaviour practice.</p>
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<p>The service has clear documentation to guide staff in the use of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. In March 2014 the service reviewed the number of restraints and with family involvement trialled removing restraint for two hospital residents through a controlled process. This resulted in one resident's restraint being removed. The service is actively reviewing restraints to keep restraint to a minimum.</p>
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<p>E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.</p>
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#### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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

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

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

Consumers receive services in a safe manner.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Only staff that have completed training are permitted to apply restraints. There are responsibilities and accountabilities determined in the restraint policy that includes responsibilities for key staff. Interviews with the restraint coordinator and review of her signed job descriptions identified understanding of the role.

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. The role of the restraint coordinator is held by the quality improvement OSH coordinator (RN) who has been in the post for eight years.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool and enabler assessment tool available and completed for the residents requiring bed rails, lap belts and chair supports. The care plans are up to date and include information on assessing the risks of safety and the need for restraint. On-going consultation with the resident (when able), and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. A restraint assessment form is completed for those residents requiring restraint. Documentation for restraints was viewed for the eight hospital residents (bed rails, lap belts and chair supports), who have restraints. Files included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed at least six monthly at round table meeting for each resident or sooner as required (written evaluation sighted).</p>

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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

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

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

Services use restraint safely

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed six monthly within the facility restraint meeting and also as part of monthly restraint register reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. On interview the restraint coordinator stated that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and was evidenced as being implemented.</p> <p>Care plans reviewed of eight hospital residents with restraint identified observations and monitoring. Eight residents who have restraints are entered in the restraint register.</p>

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred six monthly (or sooner if required) as part of the on-going reassessment for the residents on the restraint register and as part of care plan review. Families are included as part of this review (round table meeting). A review of eight hospital files with restraints identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis six monthly and monthly through restraint register review and by the facility approval team. Evaluation timeframes are determined by risk levels.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

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

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

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

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

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

**Standard 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Individuals approved restraint is reviewed six monthly (or sooner if required) through the restraint meeting and as part of the facility approval team review with whanau involvement. Restraint usage throughout the facility is analysed and information fed back to staff via all facility meetings.

**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.

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

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

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### Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The role of the infection control (IC) coordinator is held by a RN, who also acts as the clinical manager two days per week, and has been in the post for four years. The IC coordinator has IC qualifications, a diploma in teaching and attends external microbiology updates, IC DHB updates and GP information updates. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. There is an IC committee including the IC coordinator, two other RNs, a household representative, caregiver representative and maintenance representative. All members meet monthly. The IC coordinator reports to the manager who reports to the board. IC is an agenda item at quarterly service review meetings that looks at analysis, future prevention and how the IC programme is working. Analysis benchmarks with other providers (nationwide benchmarking and benchmarking with the local cluster group). The service also subscribes to Bug Control. The programme is approved and reviewed annually by the coordinator and senior management team and external expertise when required. IC is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IC</p>

practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register. There is a job description for the IC coordinator including the role and responsibilities of the position. The service has currently employed an external consultant to assist in reviewing and updating the infection control programme. Staff and residents are encouraged to have the flu vaccine.

**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.

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

**Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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

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

### Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The RN is the IC coordinator and also acts as the clinical manager two days per week. There is an IC committee including the IC coordinator, two other RNs, a household representative, caregiver representative and maintenance representative. All members meet monthly. The IC coordinator reports to the manager who reports to the board. The RNs carry information to the wards keeping staff informed and up to date. IC matters are taken to all staff and quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. She has the main responsible for reviewing the IC programme annually. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete two monthly infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.</p>

### 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.

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

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

**Standard 3.3: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Kerikeri Retirement Village has infection control policies and an infection control manual which reflect current practise. The policies and infection control manual has recently been reviewed and updated with the assistance of an external consultant. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme is reviewed annually by the IC coordinator who can access external specialist advice to do this. D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The IC coordinator is the RN that acts as the clinical manager two days per week, who has undertaken specialist IC training. All new staff receive infection control education at orientation including hand washing and preventative measures. Two monthly infection control education occurs. Five staff members have also attended an external training session on microbiology in March 2014. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents. The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff and quality meetings (minutes viewed). The facility subscribes to the Bug Control benchmarking process and receive a monthly benchmarking analysis report. The IC coordinator uses the information obtained through the surveillance of data and the benchmarking report to determine infection control education needs within the facility. Benchmarking is also compared with other local providers that meet three monthly. Internal audit of infection control is included in the annual programme and occurs two monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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