# J & R Manuel Limited

## Current Status: 18 June 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

Phoenix House provides rest home and hospital level care for up to thirty residents. During the audit there were 26 residents living at the facility including ten who required hospital level care. The manager was a registered nurse who had extensive experience in management and clinical roles at the District Health Board. The previous owner/registered nurse also continued to support the service. There was a registered nurse on duty at all times and adequate numbers of caregivers as per the staffing policy.

There was an implemented quality and risk management programme that included review of incidents, accidents, complaints and implementation of an internal audit schedule. An improvement is required to documentation of indication of use for medications.

## Audit Summary as at 18 June 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 18 June 2014

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

### Organisational Management as at 18 June 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 18 June 2014

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

### Safe and Appropriate Environment as at 18 June 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. |

### Restraint Minimisation and Safe Practice as at 18 June 2014

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

### Infection Prevention and Control as at 18 June 2014

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

## Audit Results as at 18 June 2014

### Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and received services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

### Organisational Management

Services are planned, coordinated and were appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. Quality and risk management processes are documented and maintained and reflect the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and were reported to staff along with other data collected through the staff meeting.

Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training needs are being met by the organisation with new staff receiving orientation and an implemented annual training plan.

### 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. Residents care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney and reviewed three monthly. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed three monthly following admission.

Planned activities are appropriate to the residents' interests. Residents interviewed confirmed their satisfaction with the programme. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.

An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications and have completed medication competency. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There is an improvement required around documented indication for use of prn medication on medication charts.

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 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 three spacious lounges and dining areas. There are adequate toilets and showers. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by staff. 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.

### Restraint Minimisation and Safe Practice

There is a restraint 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 a register for enablers. Currently there are three restraints (two residents) and one enabler in place. Any use of restraint or enablers is reviewed for each individual through the monthly quality/staff meeting and as part of the three monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation

### Infection Prevention and Control

The infection control programme is documented with data including the number and type of infection documented monthly and discussed at the staff meeting. There is a low rate of infections and the nurse manager, identified as the infection control coordinator takes a leading role in reviewing data. The infection control coordinator and another designated staff member implement the surveillance programme, organised training and implement and review internal audits. The infection control coordinator has access to the District Health Board, general practitioners and other specialists as required.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | J & R Manuel Limited |
| **Certificate name:** | J & R Manuel Limited |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Phoenix House Resthome and Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 18 June 2014 | **End date:** | 19 June 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 26 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX  | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 15 | Total audit hours | 39 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 10 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 29 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| 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, 18 July 2014

## **Executive Summary of Audit**

**General Overview**

Phoenix House provided rest home and hospital level care for up to thirty residents. During the audit there were 26 residents living at the facility including ten who required hospital level care. The manager was a registered nurse who had extensive experience in management and clinical roles at the District Health Board. The previous owner/registered nurse also continued to support the service. There was a registered nurse on duty at all times and adequate numbers of caregivers as per the staffing policy.
There was an implemented quality and risk management programme that included review of incidents, accidents, complaints and implementation of an internal audit schedule.
An improvement is required to documentation of indication of use for medications.

**Outcome 1.1: Consumer Rights**

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and received services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

**Outcome 1.2: Organisational Management**

Services are planned, coordinated and were appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. Quality and risk management processes are documented and maintained and reflect the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and were reported to staff along with other data collected through the staff meeting.
Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training needs are being met by the organisation with new staff receiving orientation and an implemented annual training plan.

**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. Residents care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney and reviewed three monthly. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed three monthly following admission.

Planned activities are appropriate to the residents' interests. Residents interviewed confirmed their satisfaction with the programme. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.

An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications and have completed medication competency. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There is an improvement required around documented indication for use of prn medication on medication charts.

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 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 three spacious lounges and dining areas. There are adequate toilets and showers. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by staff. 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.

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

There is a restraint 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 a register for enablers. Currently there are three restraints (two residents) and one enabler in place. Any use of restraint or enablers is reviewed for each individual through the monthly quality/staff meeting and as part of the three monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation

**Outcome 3: Infection Prevention and Control**

The infection control programme is documented with data including the number and type of infection documented monthly and discussed at the staff meeting. There is a low rate of infections and the nurse manager, identified as the infection control coordinator takes a leading role in reviewing data. The infection control coordinator and another designated staff member implement the surveillance programme, organised training and implement and review internal audits. The infection control coordinator has access to the District Health Board, general practitioners and other specialists as required.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 100 | 0 | 1 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| 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 Low | Six of 10 mediations charts sampled that have prescribed medications to be given when required do not have documented indication for use.  | Ensure that any medications prescribed which are to be given when required have documented indications for use by the GP. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive education on the Code of Health and Disability Consumers’ Rights (the Code) during their induction to the service and through the training programme. Interviews with the nurse manager, two registered nurses, three caregivers and the administrator/caregiver confirm their understanding of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

Residents interviewed including five residents in the rest home and four in the hospital confirm that their rights are upheld.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

A registered nurse discusses the Code, including the complaints process with residents and their family on admission.

Discussions relating to the Code are also held at during the six monthly residents' meetings (meeting minutes sighted) in the context of complaints and satisfaction with the service.

Resident and family interviews confirm their rights are being upheld by the service and state that they would have no hesitation in complaining if they needed to. All are also aware that they can receive outside support if they need to.

Information regarding the Health and Disability Advocacy Service and around the Code are clearly displayed in multiple locations throughout the facility.

D6,2 and D16.1b.iii:The information pack provided to residents on entry includes how to make a complaint, Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) pamphlet if requested (available in the foyer), advocacy and Health and Disability Commission information.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room.

Caregivers interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Residents and families interviewed confirm the residents’ privacy is respected.
Three of three caregivers and the administrator/caregiver interviewed report that they encourage the residents' independence by encouraging them to be as active as possible.

Caregivers can assist residents with their activity programmes and a physiotherapist is available on request.
The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).
There have been no reported instance of abuse at the facility as confirmed through discussions with the nurse manager and the administrator/caregiver.
Staff receive education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation – last provided in June 2014 (Aged Concern facilitated the training). Staff interviewed are aware of the signs of abuse and neglect.

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.

D4.1a: Three of three caregivers interviewed identify that cultural, spiritual and social individual preferences are identified.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A3.2 The service implements the Maori Health Plan and cultural safety policies to eliminate cultural barriers. The rights of the residents/whanau to practise their own beliefs are acknowledged in the Maori health plan. The nurse manager and staff are well linked into local iwi with kaumatua available from Ngati Pukenga, Ngati Whanaunga, Ngati Porou and Nga Puhi.

Coromandel has a 51% population of Maori and the service has currently six Maori residents. There is over 50% Maori staff with links into all iwi and staff who can speak te reo Maori with residents.

Local kaumatua are available to support residents and the service when required e.g. to bless rooms, to support residents requiring palliative care, to visit family members etc.
The nursing assessment includes documentation of cultural needs are identified through the assessment process (refer 1.3.3).

Staff interviewed report specific cultural needs are identified in the residents’ care plans. Staff are aware of the importance of whanau in the delivery of care for their Maori residents.
Maori events are linked to the activities programme (e.g. Waitangi Day, Mataariki).

One Maori resident interviewed praised the service for the ability to meet cultural norms and values e.g. family bring in food and the service can cook food that they bring in e.g. fish and the resident describes being supported to ‘heal’ people as per his beliefs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline.
Residents and family/whanau are involved in the assessment and the care planning processes and this is confirmed in interviews with residents and families. D4.1c Information gathered during assessment includes the resident’s cultural values and beliefs. The assessment is signed by the resident indicating their involvement. This information is used to develop a care plan and includes input from the resident and their family/whanau.

D3.1g Residents and family interviewed confirm that they are consulted on their values and beliefs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The facility implements the Phoenix House policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation.

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. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Staff use Phoenix House policies to guide practice and these are reviewed at least three yearly. These policies align with the health and disability services standards. There is a quality framework that that supports an internal audit programme.
The caregivers are encouraged to complete their ACE training (all have either completed or are currently enrolled if new staff) and annual training and competencies.

Residents and families interviewed expressed satisfaction with the care delivered.

The GP reports that a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills.

A2.2: Services are provided that adhere to the health and disability sector standards.

There is an implemented quality improvement programmes that includes performance monitoring. These are backed up by staff meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.

Family are informed if the resident has an incident, accident, has a change in health or a change in needs as evidenced in 17 of 17 completed accident/incident forms. Family/whanau contact is also recorded in residents’ files on the whanau communication form.

Interviews with family confirm they are kept informed. Family are invited to attend the monthly residents’ meetings.
Interpreter services are available when required from Waikato District Health Board. There are no residents currently requiring interpreting services.

There is a profoundly deaf staff member who uses sign language and therefore would be able to support a resident if requiring this.

Staff have completed training around communication last in November 2012.

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.

D16.1b.ii 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 Three family members interviewed (one in the rest home and two in the hospital) state that they are always informed when their family members health status changes.

Nine of nine residents including five in the rest home and four in the hospital state that there is good communication and they feel that they can talk with the nurse manager and staff at any time. The residents are part of a small community where all are known and this aids with communication.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews.

Staff are familiar with the code of rights and informed consent and describe the link between the Phoenix House philosophy and choice and consent on a daily basis. Informed consent forms are evident in all files reviewed.

There is a resuscitation policy and resuscitation decision form. This is completed appropriately in all files reviewed with only the resident deemed competent being able to sign these.

D13.1 There are admission agreements sighted and these were all signed on the day of admission.

Residents interviewed including five residents in the rest home and four in the hospital confirm that they felt appropriately involved in decision making.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families.

Written information on the role of advocacy services is also provided to residents on entry and pamphlets are given to the resident and family at this time.

Staff training on the role of advocacy services is included in training on Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) last provided in June 2014 as well as being part of the training around abuse and neglect facilitated by Aged Concern (last provided in June 2014).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has an open visiting policy.

 Residents may have visitors of their choice at any time.

The facility is secured in the evenings but visitors can arrange to visit after doors are locked or ring the bell which alerts staff. Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome.

Staff confirm that if any resident is dying, that relatives are encouraged to stay the night and remain with their family member. There is a bigger room in the hospital area with an ensuite which is used at times for relatives and the resident.
Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through churches who come in to visit individual residents.

There is one resident who currently attends church in the community.

Residents are included in shopping visits and outings with families.

The previous nurse manager and the administrator/caregiver engage with residents who wish to shop, walk or get out into the community particularly if they have no family in the area.

D3.1h Discussion with three family members indicate that they are encouraged to be involved with the service and care provided and they are free to visit at any time. This is also confirmed with the nine residents interviewed.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

The organisation’s complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint’s forms are available in the foyer.

A complaints register is place noting that the nurse manager confirms that there have been no complaints since the last audit.

D4.1d; Discussion with three family members and nine residents (five rest home and four hospital) identifies that the service provides opportunities for the family and residents to be involved in decisions and none of the family and residents interviewed could identify any opportunities for improvement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Phoenix House is a family owned and operated facility that was established in 1987.

The current owner is a registered nurse, (RN), and has owned the facility since February 2009. The current nurse manager is the daughter of the previous manager, who is also a registered nurse who provides support for residents in the service particularly when residents do not have family in the area.

The facility provides care for up to 30 residents at rest home and hospital level. On the day of the audit, there are 26 residents including 16 requiring rest home level of care and 10 requiring hospital level care.

The business plan includes the history of the service, philosophy, the kaupapa, organisational chart, responsibilities/authorities, structure of documentation and a business/quality plan that includes goals. There is a list of associated legislation. The plan was last updated in January 2014. The Phoenix House philosophy states 'The management of Phoenix House aims to be the pre-eminent provider of a range of quality healthcare services that are specific to the needs of the individual, culturally appropriate and will ensure a continuum of care for the residents of the rest home/hospital and the wider community of Coromandel.'

The nurse manager is an experienced registered nurse with a Bachelor of Nursing, a post graduate diploma in child, community and family health and a post graduate diploma in management studies. The nurse manager was previously the general manager for Maori health services at the Waikato District Health Board and has been a clinical nurse director.

Quality performance is monitored through a range of quality and human resource systems.

ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a hospital through attendance at training offered by the District Health Board and local hospice. The manager has a current practising certificate. The owners are members of the New Zealand Aged Care Association and receive information and can access advice on an on-going basis.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The previous manager takes the role of on site manager in the absence of the current manager. The previous manager still holds a current annual practicing certificate and works in the facility supporting residents as required by the nurse manager.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a business plan and quality and risk management plan that are documented by the manager and reviewed annually (last completed in December 2013 with new plans documented in January 2014).

The service has in place a range of policies and procedures to support service delivery that are reviewed at least three yearly and as changes occur e.g. through legislation. Policies are readily available to staff in hard copy in the office.
Service delivery is monitored through review of complaints, incidents, accidents, infections, and through implementation of an internal audit programme. The manager is supporting the administration/caregiver to take on a quality improvement and monitoring role with audits completed as per schedule.

The administrator/caregiver was completing the audit tool after correcting the issues and learnings from this have now resulted in the administrator/caregiver completing the tools correctly with evidence of corrective actions documented.

The service is now using the staff meeting as the meeting to discuss all aspects of the quality and risk management programme. There is a set agenda. Quality data is collected monthly with results provided to staff, evidenced in the staff meeting minutes for 2014 noting that meetings have been held in February, May and June 2014.
The most recent resident annual satisfaction survey is completed last in March 2014 with a survey of satisfaction with food services in February 2014. The results indicate that residents and family are very satisfied with services and there are no opportunities for improvement. Where corrective actions are put into place, there is documented evidence of communication with staff in the staff meeting minutes. All staff interviewed including three caregivers, the administrator/caregiver and the two registered nurses confirm that they are kept informed of quality improvements and corrective action plans.
The organisation has a risk management plan in place. The risk management plan is generated by the manager and reviewed annually. There is a designated health and safety officer who has completed level training. The health and safety officer is able to describe the role as per the job description documented. Health and safety policies and procedures, and a health and safety plan are in place for the organisation. The health and safety plan is reviewed annually. A hazard management procedure is in place with a hazards documented.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The nurse manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. The service has not had to contact any authorities since the last audit.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff and the manager.
Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.
Seventeen incident reports were selected for review. Each incident report is signed off by the registered nurse and the nurse manager retains oversight of all. There is a register of all incidents and accidents and these are discussed at the staff meetings.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 1.2.7: Human Resource Management  **(**HDS(C)S.2008:1.2.7)

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

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

**Attainment and Risk:** FA

**Evidence:**

All registered nurses and the nurse manager hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner and pharmacist.
Seven staff files were randomly selected for audit. Appointment documentation is on file including signed contracts, job descriptions and applications.

There is an annual appraisal process in place with all staff having a current annual performance appraisal completed.

First aid and CPR certificates are held in the staff files.
All staff undergo a comprehensive orientation programme (evidenced in staff files for staff employed in the past three years noting that staff who have been with the service for over 10 years do not include an orientation as this was not completed in the past).
Caregivers are paired with a senior caregiver for shifts until they demonstrate that they are able to support residents as per policy.

The organisation has a mandatory education and training programme with sessions held monthly. Sessions are provided by external providers including Aged Concern and the service is now using an on-line training for staff. Staff attendance records are held in individual staff files.

Education and training hours exceed eight hours a year.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.
The rosters for occupancy of 26 residents is as follows:
The morning shift is staffed with five caregivers (two long shifts and three short shift; afternoons with two caregivers on a long shift and one short shift and two caregivers overnight. There is always a registered nurse on 24 hours a day.

The nurse manager works full-time Monday – Friday and as required and the caregivers and registered nurses interviewed state that they are well supported by the manager and can contact the nurse manager even at home.

One of the senior caregivers is now the administrator/caregiver and is designated as part of this to have a 0.5FTE role in quality improvement activities. This supports the manager to enable more hands on support for registered nurses particularly.

There are a total of 29 staff including the nurse manager, 17 caregivers, two cleaners, two recreational therapists, four kitchen hands and seven registered nurses.
Residents and families interviewed confirm staffing is adequate to meet the residents’ needs.

##### **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:**

The service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records.

Files and relevant resident care and support information can be accessed with some information archived and some in the resident files.
D7.1 Entries are legible, include dates and are signed by the relevant caregiver or registered nurse including designation.
Individual resident files demonstrate service integration (six of six reviewed).
Medication charts are in a separate folder with medication and this is appropriate to the service.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry to Phoenix House 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. The service also has a transitional care contract and primary care contract.

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

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

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

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

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

**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. Phoenix House records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. The nurse manager reports that the service has not declined any potential residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.2, 3, and 4: The six resident files reviewed (three from the rest home and three from the hospital) identify that an initial nursing assessment and care plan is completed within 24 hours and all files identify that the long term care plan is completed within three weeks. There is documented evidence that the care plans are reviewed by the registered nurses and amended when current health changes. Five of six care plans evidence evaluations are completed at least three monthly. One resident has been at the service less than three months. Activity assessments and the activities care plans are completed by the recreational therapist.

Nine residents interviewed (four from the hospital and five from the rest home) interviewed stated that they and/or their family are involved in planning their care plan and at evaluation. Resident files included family contact records, which are completed in all resident files sampled. Family consent for when they would like to be contacted is documented in the resident’s profile.

D16.5e: All resident files reviewed identify that the general practitioner (general practitioner) has seen the resident within two working days. It is 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 is evidence as occurring on review of resident’s files with acute conditions. The GP visited on the day of the audit to review a resident following a fall. There are three general practitioners in the area. General practitioner’s visit weekly and as required. The service contacts the prime nurses after hours who then liaise with the GPs. The nurse manager confirmed that general practitioners are supportive and attentive to residents medical care needs.

A range of assessment tools are completed in resident files on admission and completed at least three monthly including (but not limited to); a) falls risk assessment, b) pressure area risk assessment, c) continence assessment and d) skin assessment. Staff can describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. A verbal handover was observed on the day of the audit. Six files reviewed identify integration of allied health and a team approach is evident.

Tracer Methodology hospital:

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

Tracer Methodology rest home:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The 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. This includes cultural and 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 and, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. There is a pain assessment completed with on-going monitoring recorded for one rest home resident requiring administration of controlled medication as part of prescribed pain management plan. Three family (one from the rest home and two from the hospital) and nine residents interviewed (four from the hospital and five from the rest home) interviewed are very satisfied with the support provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A review of six resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Six of six are current and include interventions relating to all identified areas of need. There is evidence of three monthly reviews, which are signed by a registered nurse.

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, podiatrist, dialysis nurses and geriatrician.

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

All six resident files reviewed identified that family were involved. Family contact sheets located in each resident’s files demonstrated communication with family/enduring power of attorney.

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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** FA

**Evidence:**

Six resident files were reviewed (three from the rest home and three from the hospital). There is documented evidence that the care plans are reviewed by the registered nurses and amended when current health changes. Five of six care plans evidence evaluations that are completed at least three monthly. One resident has been at the service for less than three months. Activity assessments and the activities care plans are completed by the recreational therapist. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, three caregivers, one caregiver/administrator, two registered nurses and the nurse manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers or registered nurses in the progress notes on every shift for all residents by the caregivers and daily by the registered nurses for hospital residents and as required for rest home residents (evidence in all six 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 three caregivers, one caregiver/administrator, two registered nurses and the nurse manager interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, hoist, electric beds, wheelchairs, sit on weighing scales, pressure mattresses, slippery sams, raised toilet seats, commodes, 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 (four from the hospital and five from the rest home) and three family (one from the rest home and two from the hospital) interviewed are 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 four hospital residents with wounds (a total of five wounds). All of the wounds are reviewed within the stated timeframe. There is evidence of specialist input for one hospital resident with leg ulcers .

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.

Continence management in-service is provided annually through an online training package and wound management training has been provide by the wound care Coromandel district nurses.

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 are 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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are two recreational therapists at Phoenix House who are responsible for the planning and delivery of the activities programme. One of the recreational therapists has been employed in the position for 10 years and one has only been in the position for a short time but has been employed at the service for many years. The main recreational therapists visit other facilities and meets with other activity staff. Activities are provided Monday-Friday and at weekends and evenings as required. The activities programme is combined for the rest home and hospital. Resident attend activities which are provided in the lounges, dining areas, gardens (when weather permits) or one on one input in resident’s rooms. On the day of audit residents were observed being actively involved with a variety of activities including floor games, volunteer entertainment and one on one visits. The programme is developed monthly and the weekly activities are displayed on the notice board. 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. Residents attend churches in the community with transport assistance from families and community volunteers. RSA members visit the facility and school children also visit. On or soon after admission, a social history is taken and information from this is added into the personal therapy care plan and this is reviewed three monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and 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 including exercises, quizzes, games, poetry reading, van outings, bingo and walking group. Participation in all activities is voluntary. There are a number of volunteers that visit and assist with activities or play musical instruments to entertain and engage with residents as observed on the day of the audit.

Phoenix House has its own van for transportation. Residents interviewed described attending church, going walking, enjoying the entertainment and van outings. One recreational therapist has a current first aid certificate and the other recreational therapist is scheduled to attend an update 21 June 2014.

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:** 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 1.3.8: 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:** FA

**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 three monthly or when changes to care occur as sighted in five of six plans sampled. One resident has been at the service less than three months. There are short term care plans (STCP) 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. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use include; infections, weight loss, swollen feet 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. Handover was observed during the audit.

ARC D16.3c: All initial nursing assessment/care plans are 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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 two registered nurses and the nurse manager describe the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted are to needs assessment and service coordination, dialysis nurses, geriatrician, and physiotherapist and wound care nurse.

D16.4c: The service provides 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 two registered nurses and the nurse manager identify 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept 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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital and rest home (combined). Controlled drugs are stored in a locked safe in the hospital and rest home combined and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. There is currently one resident prescribed controlled drugs. The service uses four weekly blister pack medication management system. 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.

Staff sign for the administration of medications on medication signing sheet. All 12 administration sheets sampled correlate with prescribed instructions. Four of 10 medication charts have documented indication for use. This is an area requiring improvement. The medication folders all include a list of specimen signatures. There are three medication folders and one medication trolley.

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 in March 2014. Registered nurses administer medicines. All have been assessed as competent. One registered nurse was observed administration medications at lunch time and followed correct procedure checking the medication with the GP prescription chart and signing after residents had taken the medication. Two rest home and three hospital eye drops sighted all had dates of opening. There are no standing orders. There are no resident’s self- administrating medications.

 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 Low

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital and rest home (combined). Controlled drugs are stored in a locked safe in the hospital and rest home combined and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. There is currently one resident prescribed controlled drugs. The service uses four weekly blister pack medication management system. Medication charts have photo identification. 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.

Staff sign for the administration of medications on medication signing sheet.

**Finding:**

Six of 10 mediations charts sampled that have prescribed medications to be given when required do not have documented indication for use.

**Corrective Action:**

Ensure that any medications prescribed which are to be given when required have documented indications for use by the GP.

**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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Phoenix House cooks all food on site. There is one main cook that works from Monday-Friday 6.30pm-3pm and one cook that works over the weekend. There are two tea cooks that work 4-8pm. There are kitchen hands that assist the cook and help with dishes. The main cook has been in the full time position since March 2014 and previously worked as a caregiver and some weekend cooking. The main cook is scheduled to complete food safety training in July 2014. All other kitchen staff have completed food safety training. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in May 2104. There is a council certificate for compliance with food hygiene regulations that expires 30 June 2014. The service provides meals on wheels to the community.

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. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. There are two fridge/freezers and one freezer. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Dishwasher temperature is recoded daily. Food temperatures are recorded daily.

All food in the freezer and fridge is labelled or dated and stored correctly.

The residents have a dietary profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed three monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook interviewed. The cook also visits the residents and discusses there likes and dislikes personally. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. Special diets being catered for at present include a moulied diet for one resident and one resident on renal dialysis requiring extra protein. 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 home- made baking daily. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. There is evidence that there are additional nutritious snacks available over 24 hours including cheese and crackers, sandwiches, fruit and baking.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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 are evidenced stored securely in a locked cupboard in the laundry which is a separate building from the main facility.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 27 June 2015. Electrical equipment is checked and is next due 1 April 2014. The living areas have carpet or vinyl and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. Residents are encouraged to have items of furniture with photos and ornaments. 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 the extensive grounds/gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.

The service has one hoist which was purchased in September 2013. Medical equipment has been calibrated and is next due 30 April 2015

The service has one van with a current warrant of fitness.

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

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

One hospital room has an ensuite. There are 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, families and caregivers report adequate numbers of toilets and showers in each area.

##### **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 and this was confirmed at interview with caregivers. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use the hoist with always two staff present.

##### **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 three lounges and three dining areas however the service mainly uses only two of the dining areas. 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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** FA

**Evidence:**

All laundry is completed on site. There is one staff member employed to manage the laundry 10am-1pm. All staff manage the laundry for the remainder of the day. Chemicals are stored in a locked room in the laundry in a separate building from the main facility. The cleaner’s trolley is stored in the laundry when not in use. 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 are clean and tidy in appearance.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.6: There are policies and procedures on emergencies. These policies have been reviewed within the last year.

Interviews with the caregivers and registered nurses confirm that staff are aware of emergency and security procedures.

Fire training and security situations are part of orientation of new staff and the last emergency drill has been in February and May 2014 with the New Zealand Fire Service overseeing the drill.

Fire equipment includes fire hose reels, fire extinguishers, smoke detectors and sprinklers are in place and checked annually (sighted).

A fire services company conducts monthly checks.

There is always one staff on duty with a current first aid certificate.

An approved evacuation scheme was signed off by the New Zealand Fire Service on 1 July 1994 as confirmed in a letter from the New Zealand Fire Service dated 20 May 2014.

Extra blankets are available.

There is emergency lighting at the facility and torches and batteries are stored (sighted). There is a gas stove and adequate stored water. There is at least three days’ supply of food.

Residents' rooms, communal bathrooms and living areas all have call bells. All staff are aware of the emergency process if the emergency bells are rung.

Security policies and procedures are documented and implemented by staff. Afternoon and night staff ensure all outside doors and windows are securely locked. All staff interviewed are familiar with security measures.

The service is in a small community and staff including the nurse manager and the administrator/caregiver state that in any emergency, the service is able to use local schools, RSA, marae facilities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 1.4.8: 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. There are heat pumps through the facility and every resident’s room has a fan heater. 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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The service is committed to restraint minimisation and safe practice as evidence in the restraint policy and interviews with the nurse manager, three caregivers, one caregiver/administrator and two registered nurses.

There is a documented definition of restraint and enablers, which are congruent with the definition in New Zealand Standards 8134.0. The policy includes restraint procedures

The process of assessment and evaluation of enabler use is in place. Currently there are two residents with restraints (two seat belts, and one cot side) and one resident with enabler (cot sides at night). Included in the files is an assessment process that covers alternatives and least restrictive options. The seat belts and cots side restraint is also linked to the resident’s care plan.

A register for each restraint and enabler is completed that includes a monthly evaluation.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings. Staff have attended training for restraint minimisation, challenging behaviour and de-escalation in 2013.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **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

**Attainment and Risk:** FA

**Evidence:**

The restraint co-ordinator is the nurse manager who is an RN experienced in aged care. Assessment and approval process for a restraint intervention includes the registered nurse, resident/or representative and medical practitioner. There is a job description for the restraint co-ordinator.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 2.2.2: 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

**Attainment and Risk:** FA

**Evidence:**

The service completes comprehensive assessments for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint co-ordinator (nurse manager), the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In three files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family/whanau involvement and a specific consent for enabler/restraint form is used to document approval. These are sighted in the two restraint files reviewed.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The two files reviewed had a completed assessment forms and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. Two files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms have been completed. Assessments are completed. A monthly review and three monthly evaluation of restraint are completed that reviews the restraint episode. The service has a restraint and enabler register for the facility that is updated each month.

##### **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.

**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 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.

**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 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The service has documented review of restraint every month. Residents with restraint are discussed at monthly staff meetings. There are documented three monthly evaluations. In the two restraint files reviewed, evaluations are completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator (nurse manager) at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.

##### **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.

**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 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed monthly and three monthly evaluations or sooner if a need is identified. Reviews are completed by the restraint co-ordinator with the resident, family/whanau and medical practitioner. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly staff 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The nurse manager is the infection control (IC) coordinator with support from another staff member to record data and can access external specialist advice from general practitioners, laboratories and District Health Board infection control specialists when required.

The infection control programme is appropriate for the size and complexity of the service.

The programme is approved and reviewed twelve monthly by the nurse manager (last reviewed in December 2013).
Infection control is a standing agenda item at the staff meeting minutes (minutes viewed).
Staff are informed about infection control practises and reporting.
There is a job description for the IC coordinator including the role and responsibilities. There are policies and an infection control manual to guide staff to prevent the spread of infection.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The nurse manager is the IC coordinator and IC matters are taken to the staff meeting minutes. The IC coordinator can access external District Health Board IC nurse specialist, laboratories, and general practitioner specialist advice when required – confirmed by the general practitioner interviewed.
The IC coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. The nurse manager (infection control coordinator) and support infection control coordinator have completed training in March 2014.

Staff complete annual infection control training with the last being provided to staff in August 2013.

The infection control coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

**Attainment and Risk:** FA

**Evidence:**

The service has infection control policies and an infection control manual which reflect current practise. All policies related to infection control have last been reviewed in August 2013.
The IC programme and job description 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.

D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections, hand hygiene, standard precautions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The IC coordinator is a registered nurse – nurse manager. Training has last been completed in March 2014.
All new staff receive infection control education at orientation including hand washing and preventative measures (confirmed by the two registered nurses and three caregivers interviewed).
Annual infection control education was delivered in August 2013. The staff files record the staff education and attendance.

Resident education occurs as part of care delivery.
There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. There have been no outbreaks since the last audit.

##### **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 who is a registered nurse. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the service are appropriate to the acuity, risk and needs of the residents.
The IC coordinator and support staff enter the number and type of infections on to the infection and this is reported at the staff meeting. The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.
Communication between the service and the GP regarding infection control is reportedly responsive and effective. The general practitioner confirms that there is notification if there is any resistance to antimicrobial agents. There is evidence of general practitioner involvement and laboratory reporting.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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