# St Johns Hill Healthcare Limited

## Current Status: 2 July 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

St John’s Hill Healthcare is a 56 bed facility in Whanganui that provides rest home and hospital care. At the time of the certification audit, the service has been operating for approximately nine months.

The managers and staff demonstrate a commitment to providing a high level of care in a clean, well maintained and restful environment. They also demonstrate continuous improvement in their implementation of the quality and risk management systems, in particular in relation to the development, implementation, review and evaluation of corrective action plans and quality improvement projects intended to address areas requiring improvement.

There were two areas identified as requiring improvement. These include the need for care plan evaluations to inform the level of response to documented interventions, and the need to implement a medicines reconciliation process.

## Audit Summary as at 2 July 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 2 July 2014

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

### Organisational Management as at 2 July 2014

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

### Continuum of Service Delivery as at 2 July 2014

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

### Safe and Appropriate Environment as at 2 July 2014

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

### Restraint Minimisation and Safe Practice as at 2 July 2014

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

### Infection Prevention and Control as at 2 July 2014

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

## Audit Results as at 2 July 2014

### Consumer Rights

Care provided to residents at St John’s Hill Healthcare is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. St John’s Hill Healthcare has residents who identify as Maori and there is evidence of a comprehensive plan of care documented that supports their cultural needs.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is known to the service (through an arrangement with Aged Concern) and is available if required. St John’s Hill Healthcare encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

There is a culture within the service whereby complaints are encouraged as a means towards improving services. Information on how to make a complaint is readily available to residents, staff and family members. According to a complaints register and completed and reviewed complaints forms, all complaints are being followed up and changes are made accordingly.

### Organisational Management

A philosophy of caring, with the intention for residents to be as independent as possible, is evident in the mission and values statements for the service. A current strategic business plan is in place, as are up to date quality and risk management plans.

Suitably qualified general, facility and clinical managers are responsible for the service. Policies and procedures developed last year remain current with changes being made as required. The quality management system is underpinned by ongoing analysis and review of data that is collected from the key components of the system, including incident reports, complaints, internal audits, staff, resident and relative meeting feedback, infection control surveillance and restraint monitoring. There is attention to detail paid to all aspects of quality and risk management with all documentation showing reviews are occurring in a timely manner. The overall standard for quality and risk management is demonstrating a level of continuous improvement and this is most evident in the development, implementation and evaluation of corrective action plans and quality improvement projects.

Professional staff have current annual practising certificates, new staff are undergoing supported orientation programmes and staff are undertaking ongoing education and training opportunities.

Staffing levels are safe, meet the requirements of the provider agreement with the district health board and are subject to ongoing review by the management team, according to acuity and occupancy in particular.

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

### Continuum of Service Delivery

Information packs for St John’s Hill Healthcare contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted show that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate their family. There is an improvement required related to evaluation of interventions. There is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected.

An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. Residents participate in events organised by other residential aged care homes and there are specifically designed activities for the younger resident.

Well defined medicine policies and procedures guide practice, however not all practices are consistent with these documents. There is a documented process in place to manage the reconciliation of medicines, when they arrive from the pharmacy; however, there is currently not any evidence available to indicate that this process is being implemented according to requirements. This is an area requiring improvement.

The current winter menu has been reviewed by a dietitian and food is served according to individualised dietary profiles of residents that are completed on their admission. Food purchase, storage, preparation and disposal is being undertaken according to accepted processes with ongoing monitoring and reviews ensuring that safe practices are upheld. Only favourable feedback about the meals is provided.

### Safe and Appropriate Environment

There is attention to detail in both internal and external environments. Ongoing monitoring and review of a range of equipment and environmental aspects is occurring according to a comprehensive schedule. Rubbish is being disposed of in a safe manner and personal protective equipment is available. The building warrant of fitness is current and any ongoing maintenance and repairs are being undertaken within a maximum of two days.

All residents’ internal areas are spacious with attention to detail in the décor and miscellaneous artwork is displayed. There are additional seating areas for visitors to move to as preferred. Externally, there are options of paved paths and courtyards, garden and lawns areas some of which are safe and ramped for easier access. Most residents’ rooms have an ensuite attached; otherwise there are communal showers and toilets on both levels of the building.

An evacuation plan has been approved by the fire service and staff are trained in emergency management. A well-stocked civil defence kit is available, alternative energy sources and water supplies are available, a modern call bell system is installed and security systems in place meet the needs of this service.

Residents’ rooms and communal areas all have windows that allow natural light through and the facility is heated by hot water filled radiators. On the day of audit the heaters in one section of the facility are too hot to touch and a hydroboil unit requires a safety mechanism. Action is taken on both concerns during the audit.

### Restraint Minimisation and Safe Practice

Restraint minimisation policies and procedures are available and the definition of an enabler meets the requirements of the standard. There are not currently any restraints being used in this facility. Two residents choose to use bed rails as enablers and these are supported by assessment and consent processes with ongoing monitoring and reviews of their use.

### Infection Prevention and Control

The service is able to demonstrate it provides a managed environment, which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinators reporting directly to the facility manager who reports to the general manager.

There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse and the facility manager is responsible for this programme, including education and surveillance.

Infection control policies and procedures are due to be reviewed annually; however evidence of this is not sighted as the policies have not yet been implemented for a year. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | St Johns Hill Healthcare Limited |
| **Certificate name:** | St Johns Hill Healthcare Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | St Johns Hill Healthcare | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 2 July 2014 | **End date:** | 3 July 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 45 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 18 | Total audit hours | 50 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 14 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 48 | Number of relatives interviewed | 11 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 23 July 2014

## **Executive Summary of Audit**

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| **General Overview** |
| St John’s Hill Healthcare is a 56 bed facility in Whanganui that provides rest home and hospital care. At the time of the certification audit, the service has been operating for approximately nine months. Not all of the currently occupied 45 beds were filled with people requiring long term care as the service also provides intermediate care.   The managers and staff demonstrate a commitment to providing a high level of care in a clean, well maintained and restful environment. They also demonstrate continuous improvement in their implementation of the quality and risk management systems, in particular in relation to the development, implementation, review and evaluation of corrective action plans and quality improvement projects intended to address areas requiring improvement.   There were two areas identified as requiring improvement. These include the need for care plan evaluations to inform the level of response to documented interventions, and the need to implement a medicines reconciliation process. |

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| **Outcome 1.1: Consumer Rights** |
| Care provided to residents at St John’s Hill Healthcare is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. St John’s Hill Healthcare has residents who identify as Maori and there is evidence of a comprehensive plan of care documented that supports their cultural needs.  Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.   A local independent advocate is known to the service (through an arrangement with Aged Concern) and is available if required. St John’s Hill Healthcare encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.  There is a culture within the service whereby complaints are encouraged as a means towards improving services. Information on how to make a complaint is readily available to residents, staff and family members. According to a complaints register and completed and reviewed complaints forms, all complaints are being followed up and changes are made accordingly. |

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| **Outcome 1.2: Organisational Management** |
| A philosophy of caring, with the intention for residents to be as independent as possible, is evident in the mission and values statements for the service. A current strategic business plan is in place, as are up to date quality and risk management plans.  Suitably qualified general, facility and clinical managers are responsible for the service. Policies and procedures developed last year remain current with changes being made as required. The quality management system is underpinned by ongoing analysis and review of data that is collected from the key components of the system, including incident reports, complaints, internal audits, staff, resident and relative meeting feedback, infection control surveillance and restraint monitoring. There is attention to detail paid to all aspects of quality and risk management with all documentation showing reviews are occurring in a timely manner. The overall standard for quality and risk management is demonstrating a level of continuous improvement and this is most evident in the development, implementation and evaluation of corrective action plans and quality improvement projects.  Professional staff have current annual practising certificates, new staff are undergoing supported orientation programmes and staff are undertaking ongoing education and training opportunities.   Staffing levels are safe, meet the requirements of the provider agreement with the district health board and are subject to ongoing review by the management team, according to acuity and occupancy in particular.  Residents’ admission information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to date and relevant consumer records. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Information packs for St John’s Hill Healthcare contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.  There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted show that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate their family. There is an improvement required related to evaluation of interventions. There is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected.   An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. Residents participate in events organised by other residential aged care homes and there are specifically designed activities for the younger resident.   Well defined medicine policies and procedures guide practice, however not all practices are consistent with these documents. There is a documented process in place to manage the reconciliation of medicines, when they arrive from the pharmacy; however, there is currently not any evidence available to indicate that this process is being implemented according to requirements. This is an area requiring improvement.  The current winter menu has been reviewed by a dietitian and food is served according to individualised dietary profiles of residents that are completed on their admission. Food purchase, storage, preparation and disposal is being undertaken according to accepted processes with ongoing monitoring and reviews ensuring that safe practices are upheld. Only favourable feedback about the meals is provided. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There is attention to detail in both internal and external environments. Ongoing monitoring and review of a range of equipment and environmental aspects is occurring according to a comprehensive schedule. Rubbish is being disposed of in a safe manner and personal protective equipment is available. The building warrant of fitness is current and any ongoing maintenance and repairs are being undertaken within a maximum of two days.   All residents’ internal areas are spacious with attention to detail in the décor and miscellaneous artwork is displayed. There are additional seating areas for visitors to move to as preferred. Externally, there are options of paved paths and courtyards, garden and lawns areas some of which are safe and ramped for easier access. Most residents’ rooms have an ensuite attached; otherwise there are communal showers and toilets on both levels of the building.  An evacuation plan has been approved by the fire service and staff are trained in emergency management. A well-stocked civil defence kit is available, alternative energy sources and water supplies are available, a modern call bell system is installed and security systems in place meet the needs of this service.   Residents’ rooms and communal areas all have windows that allow natural light through and the facility is heated by hot water filled radiators. On the day of audit the heaters in one section of the facility are too hot to touch and a hydroboil unit requires a safety mechanism. Action is taken on both concerns during the audit. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Restraint minimisation policies and procedures are available and the definition of an enabler meets the requirements of the standard. There are not currently any restraints being used in this facility. Two residents choose to use bed rails as enablers and these are supported by assessment and consent processes with ongoing monitoring and reviews of their use. |

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| **Outcome 3: Infection Prevention and Control** |
| The service is able to demonstrate it provides a managed environment, which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinators reporting directly to the facility manager who reports to the general manager.   There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse and the facility manager is responsible for this programme, including education and surveillance.  Infection control policies and procedures are due to be reviewed annually; however evidence of this is not sighted as the policies have not yet been implemented for a year. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 42 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 90 | 0 | 2 | 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 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.2 | Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | In six of nine files reviewed there is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected. | Show evidence of documented evaluation of the support and/or intervention and documented progress towards meeting the desired outcome of the residents. | 180 |
| 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 | There is a documented process in place to manage the reconciliation of medicines, when they arrive from the pharmacy; however, there is currently not any evidence available to indicate that this process is being implemented according to requirements. | Demonstrate the implementation of an appropriate process to manage reconciliation of medicines and have documented evidence this is in place. | 180 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | CI |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | CI | Any aspect of the services delivered, the environment, or the systems in place at St John’s Hill Healthcare that show any evidence of falling short of the high level expectations, is immediately investigated and a corrective action is implemented. A corrective action plan is developed, with a designated person allocated to follow it through. It is logged, implemented, reviewed and evaluated for effectiveness. Updates on each are being reported and discussed at all levels of the organisation. Full quality improvement projects are developed for issues that are identified as being of a higher level of risk, or affecting a wider number of people. The manner in which this service addresses areas requiring improvement is occurring at a level of continuous improvement. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare is observed to provide an environment in which residents receive services in accordance with human rights legislation. Management (four of four) and staff (12 of 12) are familiar with the Code of Health and Disability Services Consumers’ Rights (the Code) as evidenced during conversation with them and in sighted policy documents.  Staff receive education on the Health and Disability Commissioner’s Code (the Code) at orientation and through in-service training as sighted in staff records (seven of seven employment, orientation and training records) and planned education programmes, and verified by interviews with staff. Residents (two of two hospital residents, four of four rest home residents) and family/whanau interviews (eight of eight) verify the service complies with consumer rights legislation.   Clinical staff (11 of 11) are observed to explain procedures being undertaken, seek verbal acknowledgement for a procedure to proceed prior to it being commenced, protect residents' privacy (e.g., notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and address residents by a preferred name.  The ARRC requirements are met. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment in which residents are informed of their rights. Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service with information brochures clearly displayed and accessible to all residents (sighted).  Residents receive a copy of the policy of resident’s rights and responsibilities in the admission information pack, with opportunities for discussion, clarification and explanation available at admission and any other time as necessary. Information is also provided on, access to support services, information on long term residential care for older people, information on applying for a residential care subsidy, and the facilities range of services and costs. Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time.   Advice on accessing interpreters is available should assistance be required to provide the information in a language and format that is suitable to the resident. The facility has access to a residents’ advocate through Aged Concern if needed.   All of the above is verified by staff, resident and family interviews.   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. Bedrooms are of a size that allows appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff always knock on their door prior to entering. The nurses’ stations (2) provides privacy of stored information. Privacy when discussion concerning residents takes place is in residents' rooms or the whanau room. Staff education around residents’ rights and privacy takes place at orientation, and during in-service education.   Residents receive services that are responsive to their needs values and beliefs. Care plans identify residents like and dislikes and interventions identify the assistance the resident requires to meet residents' needs, while being encouraged to be as active as possible. Residents are addressed in a respectful manner and by their preferred names, are assisted to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.  Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The individual employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. There are no concerns expressed related to abuse or neglect.   Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives. Staff demonstrate an awareness of the need to provide a service that is responsive to these needs. Evidence of this is observed, sighted in resident and staff files reviewed and verified in resident, family and staff interviews.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare recognises the special relationship between iwi and the Crown and appreciates the principles of The Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing.  There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organisation’s model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. Two of two files reviewed of residents who identify as Maori, have a comprehensive plan of care documented that supports their cultural needs, as verified by file review and resident interview.  Local iwi supports the facility and presents education and advise related to cultural safety where required.  Staff receive annual education in relation to cultural safety and The Treaty of Waitangi.  The requirements of the ARRC are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment that enables residents to receive culturally safe services which recognise and respect individual ethnic, cultural and spiritual values and beliefs.   Included in the admission and ongoing assessment process, residents and/or family/whanau are consulted about individual values and beliefs. Any special cultural, spiritual, values and beliefs requirements needed to be met by the service are identified and documented to inform the care planning and activity planning process to ensure that residents’ specific needs and objectives are met.  The service has a chapel and clergy who visit regularly to provide Anglican and Catholic church services as sighted in the activities programme. Other requests can be arranged with management and some residents’ families access their own spiritual support from the community. Open visiting policy allows family/whanau to visit when they are able. Staff receive yearly in-service training on cultural safety and the Treaty of Waitangi.  Evidence to support findings is sighted in resident file reviews, observation and staff training records. Resident and family/whanau interviews confirm staff implement cares to meet their needs.   The ARRC requirements are met. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.  Orientation/induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and informs staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements. The manager will action formal disciplinary procedure if there is an employee breach of conduct.  Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. As evidenced in staff files, observation and verified in staff, resident and family interviews.   The ARRC requirements are met. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment that encourages good practice. All policies sighted are up to date, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales, which are monitored and evaluated at organisational and facility level.  Human resources are managed to employ competent employees. New employees complete a comprehensive orientation/induction programme that is relevant to the role being undertaken. Staff records evidence competent employment practices, orientation and training records. The service supports and encourages staff with appropriate on-going education relevant to the role they undertake. The service has an extensive and diverse in-service education programme in place which is monitored at organisational level to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. Staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner.  Incident reporting systems are evidenced to be linked to open disclosure and quality improvement processes.  All care staff have or are undertaking the Aged Care Education programme and dementia training. Registered nurses (RNs) who administer and/or check medication have yearly assessments to determine competency (sighted). Senior care staff have yearly competencies to enable them to “check” accuracy of medication for the RN’s where the medication is to be checked for accuracy by two persons (sighted) or they have competencies to administer medication in the rest home.   Registered Nurses (RNs) and senior care staff have an up to date first aid certificates (sighted). Ongoing education for RNs is supported by the facility, the Wanganui District Health Board, the specialist services that they operate and the local Hospice services. Kitchen staff have qualifications in Safe Food Handling  Residents and relatives interviewed verify satisfaction with the services provided.  An interview with the GP, verifies despite initial teething problems when the facility first opened, which have now been resolved, he is satisfied with the services provided. The service responds promptly and correctly to requests and is prompt in requesting input if needed.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment conducive to effective communication.  Communication with relatives is documented in the communication sheet which is kept in the resident’s file, and sighted incident and accident forms evidence resident and/or family are informed of incidents, when requested. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Staff confirm they understand that relatives and residents must be informed of any changes in care provision.   There are no residents that require interpreting services; however management staff are aware of how to access interpreters if this service should be required.  Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).  Residents and family interviews confirm communication with staff is open and effective, that they are always consulted and informed of any untoward event or change in care provision.   The ARRC requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides residents and where appropriate their family/whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/ whanau on admission. Consents requests the resident's agreement to; collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process.  Files reviewed evidence informed consent forms signed on admission and identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. Medicine charts have residents’ photographs for identification. Residents’ choices and decisions are recorded and acted on.   An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non-consent to be revoked at any time. The advance directive also requests the residents’ acknowledgement they have been informed of their rights. Advance directives are sighted in files reviewed.  Verbal consent is obtained prior to an intervention being carried out as observed and verified in clinical staff, residents and family interviews.   Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process and confirm their understanding of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. The environment is observed to be one where choices are offered and openly acknowledged.   Resident and family interviews confirm there are provided with the necessary information to make informed choices, choices are respected by staff and staff confirm they respect the resident's right to decline refuse consent at any time.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare recognises and facilitates the right of residents to advocacy/support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility and on notice boards around the facility. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons, as verified in clinical staff, residents and family interviews. The facility has an arrangement with Aged Concern to provide advocacy services if required.   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment whereby residents are able to maintain links with family / whanau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges values and encourages the involvement of families/whanau in the provision of care and the activities programme actively supports community involvement and accesses community resources.   Resident and family interviews confirm that visitors can visit freely and there is free access to community services. It is observed that there were visitors coming and going from the facility during the audit. File reviews, manager, RN and the recreational officer confirm community services used by the facility include: - local social groups - other aged care facilities - local church groups and services - The local needs assessment and service coordination agency (NASC)  - the service has a podiatrist who visits regularly - residents have the GP of their choice - Wanganui DHB outpatient and inpatient services as appropriate - Hospice service  The ARRC requirements are met |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A copy of the complaints policy is sighted and meets the requirements of right 10 of the Code. The policy includes reference and contact details of the Health and Disability Commissioner and of the advocacy service.  The facility manager informs that either she or the clinical manager go through the complaints process with all new residents and their families on admission, at each relatives’ meeting and at each residents’ meeting. During a group interview with eight staff all are aware of the complaints process. One person informed of a staff complaint and informed that full resolution had occurred. Copies of complaints forms are sighted at the foyer in the entrance of the facility and information about how to make a complaint is in the admission package.  Eleven complaints are listed in a complaints register, which notes the complaints form number, resident or staff name, the date the complaint was lodged, actions taken, dated solution implemented, date complaint resolved, manager signature. The complaints register has no evidence of any complaints having been received from the District Health Board, or from the Health and Disability Commissioner, and all complaints in the register have evidence of follow-up and resolution. All complaints forms have detailed reports of actions taken and copies of associated correspondence. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A mission statement dated June 2013 focuses on ensuring a comfortable, cheery environment for the residents and that the care is of the highest standard and appropriate for dependent people. The service strives to create a living and working environment, which promotes dignity and respect.   The philosophy of the service, last reviewed August 2013 prior to the opening of the facility, is to promote a respectful, caring and resident focused environment, where the residents will be supported and encouraged to maintain as much independence as is safe, in a comfortable care setting. Residents will be treated as individuals and shown patience, dignity and compassion.  A husband and wife team, who have been in the industry for 13 years, own the facility and one other in Christchurch. They are actively involved in the strategic management of the service and receive key documents, including those related to staffing use, occupancy and management and quality/staff meeting minutes. There is an overarching general manager who oversees the budgets and the strategic management of this service, as well as one other service in Christchurch, where she is based.   A facility manager accepts responsibility for the overall management of St John’s Hill Healthcare. She informs she is a registered nurse with previous clinical and operations management experience. Evidence of these experiences are sighted in her curriculum vitae and her personnel file. Her previous management experience was within a large corporate aged care organisation and dementia services. Other areas of extensive experience sit within training and coaching. The facility manager is maintaining her annual practising certificate and her personnel file shows she is attending further training in topics such as medicine management, restraint minimisation and leadership. She is linking closely with the local District Health Board education unit and receives additional mentoring and business coaching from the regional manager. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical manager is responsible for management of the service in the absence of the facility manager, however the general manager based in Christchurch is available to offer support and advice when required. According to the personnel file and the curriculum vitae of the clinical manager, she is a registered nurse with an annual practising certificate experience. She has had previous management experience of aged care facilities and works alongside the general manager on a day to day basis. The training record in her personnel file shows she is maintaining her professional development, including aspects of facility management and topics related to clinical issues. |

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| There is a detailed quality assurance plan (June 2013) that includes 11 objectives around services that are client focused and respect individual’s needs, delivery of a consistently high standard of services, empowering relationships with stakeholders, timely and comprehensive staff orientation and training, ongoing implementation of current best practice, supporting residents’ independence in surroundings that are comfortable safe and spacious, encouragement of residents, families and staff in all activities, utilisation of a multidisciplinary model of service delivery and the effective purchase and utilisation of resources and consumables. A quality strategy outlines the principles of effectiveness, efficiency, equity, access, acceptability, appropriateness, respect, choice, availability, and clinical competence.   The general manager informs the service employs a quality consultant to oversee the policies and procedure, to provide additional information and advice as required and to act as a mentor for the managers. The quality assurance and risk management plan includes management of the organisational policies and procedures. Documents are to be reviewed according to an index form in the master file (sighted) and as the service is not yet one year old the general manager confirms they are current until June 2015, although there is evidence that changes are being made when required. Each policy document records the date it was written and the date for its next review.   Evidence of implementation of the quality assurance plan is sighted in the comprehensive internal audit programme, the minutes of management, staff, relative and residents’ meetings, the monitoring of a health and safety programme and of the risk management plan. A consumer satisfaction survey and relative and staff feedback ones are on the list of monitoring processes, however these were not undertaken on the allocated month as the management did not consider the service had had sufficient clients for long enough and this task is planned for later in 2014.   There is a quality improvement committee consisting of the management team and key staff with specific responsibilities such as restraint, infection control and health and safety as well as representation from staff categories, such as registered nurses, caregivers, kitchen, cleaning, laundry and maintenance. This group meets monthly. An agenda template is used and covers key components of the quality management system such as complaints, incidents/accidents, restraint use, health and safety, risk management, annual safety training requirements and fire evacuation drills, reports from each service area, residents and relatives meeting minutes, internal audit results and quality improvement suggestions.   Corrective action processes are being implemented in a manner that demonstrates continuous improvement. Such processes are used for any area that is not meeting the expectations within any aspect of the service’s systems. A plan is developed on how to address the issue, the implementation is reviewed at each step and an evaluation of how well it is working is made. Each step is documented in meticulous detail and informs who is responsible for implementing it, who is responsible for overseeing it, how and when it will be reviewed, what the expected outcome is and whether there are any other stages to it, or other potential influencing factors. These processes are currently being led by the facility manager who uses them alongside full quality improvement projects to ensure changes are made. There are a number of examples of such projects including around medicine errors and an effort to reduce the number of residents’ falls and improve residents’ safety.   A detailed internal audit programme for all areas of service delivery and risk management is being implemented according to a comprehensive matrix with reports on each one undertaken. The reports are full with attention to detail, include implementation of corrective actions as required and an evaluation and review of the effectiveness of changes made.   Risks are identified and assessed under the topics of safety management; security management; hazardous materials management; emergency preparedness; and equipment management. A risk register is in place to detail items of potential risk and their management strategy. All are current and are being reviewed according to the specified aspects of the quality system such as implementation of the health and safety programme, internal audits and the analysis of incident data for example.   Due to the consistency of the implementation of the quality and risk management system, the meticulous nature of the documentation for the different aspects of the quality management systems and the specific evidence of continuous improvement in the corrective action processes and the quality improvement projects, the overall standard is considered as showing evidence of ongoing continuous improvement. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| There are multiple examples of corrective actions being implemented throughout this organisation, from immediate actions on equipment repairs or building maintenance to full scale quality improvement projects. Any area identified as requiring improvement, either to meet a specified standard, or one of their own organisational expectations, is addressed in as short a time as possible and is documented. A timeframe on corrective action reviews is seven days and there is evidence that this is occurring. All open corrective actions are discussed at the relevant meeting(s) such as resident, restraint committee or management meeting, and then taken through to the quality and staff meeting. A corrective action plan may already have begun to be implemented, otherwise a plan is developed. All such actions and plans are being recorded and logged, all are dated and the facility manager personally reviews the logs to ensure all follow-up, review and evaluation has occurred.   Despite the short time of operation (approximately nine months) these processes filter through all levels of the quality and risk management system. Internal audits have revealed items not where they should be, or a level of care or documentation not as high as expected, and relevant corrective actions are taken and review processes implemented. For example, any medication error is consistently being followed by a mandatory review of the person’s competency of medication administration; and any change in water temperature recording is checked by a plumber and the temperature rechecked several times following the maintenance prior to it being closed. There are examples of well-developed quality improvement projects. These demonstrate an issue has been identified as requiring improvement and the facility manager, the management team, or the quality group consider the solution is more complex and may affect a larger number of people and/or the risk is higher and needs a more in-depth approach to resolve it. Four such examples of these that are sighted and reported include hot water temperatures in certain rooms in January; a higher incidence of pressure areas than expected among hospital level care residents; an increase in medication errors and an increase in the number of residents who were falling. All have the issue clearly identified following a full analysis, all are fully documented, have detailed plans, ongoing review processes and evaluations demonstrate each was resolved in an effective manner. There is good evidence to demonstrate that the manner in which corrective action plans and quality improvement projects are being implemented to address areas requiring improvement is demonstrating continuous improvement. |
| **Finding:** |
| Any aspect of the services delivered, the environment, or the systems in place at St John’s Hill Healthcare that show any evidence of falling short of the high level expectations, is immediately investigated and a corrective action is implemented. A corrective action plan is developed, with a designated person allocated to follow it through. It is logged, implemented, reviewed and evaluated for effectiveness. Updates on each are being reported and discussed at all levels of the organisation. Full quality improvement projects are developed for issues that are identified as being of a higher level of risk, or affecting a wider number of people. The manner in which this service addresses areas requiring improvement is occurring at a level of continuous improvement. |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Incident forms are being consistently completed for adverse events, which are then being followed up and reviewed by the facility manager, as per the organisational policies and procedures. The facility manager informs these may also be discussed with the regional manager. During an interview with eight staff, all are familiar with the incident reporting process and the need to complete these and they state that they receive information about follow-up and about trends at the staff meetings.   Management and staff meeting minutes reflect the incident reporting and review process, graphs are developed to illustrate trends and logs have been developed separately for staff incidents and for resident related incidents. Completed incident forms are filed in the respective person’s file and examples of these are sighted. There is evidence of open disclosure being undertaken both on incident report forms and in communication logs of residents’ files. As noted in standard 1.2.3, the documentation around incident reporting is also being completed in meticulous detail.   The facility manager is aware of essential notification reporting processes and provides details about two examples of incidents for which other authorities were advised and/or the service co-operated with for investigation processes. These included HealthCERT, the District Health Board and the Accident Compensation Corporation (ACC). Both incidents are fully documented and there is good evidence of follow up with a quality improvement project developed, implemented and evaluated to address an underlying issue related to these incidents. The facility manager is also able to inform of other reporting requirements that may arise such as informing public health authorities in the event of an outbreak, notifying the Ministry of Health of any deaths and advising the District Health Board of significant changes to the service or in the event that a person receiving intermediate care need to return to hospital. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A folder of copies of annual practising certificates and records of the expiry dates is sighted and includes those for the service’s physiotherapist, podiatrist, all of the pharmacists at the main pharmacy used by the service, the house doctor and all other GPs in Wanganui (who may have short term clients) and those for nine registered or enrolled nurses. All are current. Copies of the nurses’ annual practising certificates are also held on their personnel files.   As resident occupancy has gradually increased since the opening of the facility in October 2013, the staff numbers have increased accordingly. Consistent employment processes have occurred and this is evident in all of the ten staff files reviewed, which are a representative cross section of positions. All staff files have evidence of completed applications and of initial interviews having occurred, five have curriculum vitae (this is optional in their application) and all have records of at least two referee checks and a signed employment contract. As the human resources policies and procedures state performance appraisals will be undertaken annually and the service has not yet been operating for a year, none of the staff have a performance appraisal on file. There are records of the general manager monitoring the performance of one staff persona and this is occurring according to best practice.  A comprehensive orientation/induction programme is in place, as is an orientation checklist that covers staff knowledge of mandatory documents such as the house rules and some named policies and procedures, operational processes such as waste management and fire evacuation procedures, interviews with other staff such as the health and safety officer and a range of competencies that include a fire knowledge test, manual handling and an infection control quiz. Completed documentation of these checklists is in all except two of the staff files reviewed. The two without evidence of a completed orientation checklist have only recently been employed and their orientation is still underway. During the interview with eight staff, all are positive about the quality and value of the orientation programme, especially the ‘buddy’ system that is maintained as long as is deemed necessary by all parties concerned. This is made possible by the allocation of staff into teams of two during each shift.  Staff training is supported by an ongoing in-service training programme for which staff are paid to attend and external presenters are also asked to contribute. A 2014 in-service programme based on the District Health Board requirements for staff working in rest home and hospital for aged care is sighted. Topics include Code of Rights/privacy and health and safety (January), documentation/restraint and first aid (February), medication management and transferring residents/manual handling/falls prevention (March), dementia care and non-clinical emergencies (April), Treaty of Waitangi and Maori health (May), infection prevention and control and fire, (June) and abuse and neglect (July). The programme for the remainder of the year is also sighted. Attendance records are being maintained for individual sessions and for individual staff in their personnel files (sighted in those reviewed). Registered nurses are working with the District Health Board for their professional development and have a range of options of external training they can attend. The range of competencies that individual staff may or may not be required to demonstrate, (depending on their role and responsibilities) includes ones for medication: basic, administration of basic medication, administration of controlled drugs, second checker of controlled drug weekly stocktake, manual handling, insulin competency, hand-washing, infection control, fire protection and restraint/enabler use. All caregiver staff are expected to undertake the Aged Care Education (ACE) training package. Only four (all recent employees) have yet to register. Thirteen caregivers have completed their ACE basic, 11 have also completed their dementia module and 12 have completed their advanced. The facility manager makes herself available to all staff to discuss any aspect of staff education. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An annual leave and rostering policy that includes a section on general guidelines, staff/skill mix, what the routine roster consists of and procedures for replacing staff and changing shifts for example is sighted.   The facility manager is responsible for development of the rosters. The general manager uses the standard ‘Indicators for safe aged care staffing allocations’ to develop staffing hours according to occupancy. The facility manager then uses these allocations as a guideline, which is further adapted according to acuity levels and actual occupancy during that fortnight. The hours required according to expected occupancy for each month in 2014, and the actual hours used, are sighted. The difference shows that a higher number of hours than were actually required (according to the formula) have been used every month this far, which the general and facility managers attribute to changing occupancy and acuity levels of residents. A resident informs of staff getting very busy at times and staff also raise this during interview. There is no documented evidence that this is an issue of concern and there is a system in place for staff to provide a task list for shifts that they believe have felt difficult to manage. No such reports have been provided and staff meeting minutes do not show that this has been raised as a concern.  Three weeks of a typical roster are reviewed and shifts and staff allocation are reviewed. Although all beds can potentially be used for residents requiring either hospital or rest home care, all of the beds on the first floor are rest home except for two, which are occupied by residents receiving hospital level care. All residents on the ground floor are hospital level care. A base roster of minimum staff allocation that is based on the current occupancy on the day of audit is as follows:   First Floor: 7am to 3pm has an enrolled nurse or a registered nurse with two care givers rostered on duty; 3pm to 11pm has a senior caregiver and one other on duty and the 11pm to 7am has a night duty caregiver rostered on.  Ground Floor: The clinical leader is rostered on 7am to 3pm Monday to Wednesday (although she also works Thursday and Friday, these days are dedicated to clinical management tasks). Another registered nurse works Thursday to Sunday. Two caregivers work 7am to 3pm and one does 7am to 11am. Another caregiver works 9am to 1pm. Afternoon shifts consist of a registered nurse and two caregivers working 3pm to 11pm and another caregiver works 5pm to 8pm. This person extends to 11pm if a resident is unwell of additional assistance is needed. The night shift has a registered nurse and a caregiver on duty from 11pm to 7am.   The downstairs registered nurse will go upstairs when required. There is registered nurse cover 24 hours a day on seven days a week and the facility manager is also a registered nurse with a current practising certificate and will also assist when required. A minimum of one person with a current first aid certificate is rostered on each shift and this is indicated by an asterisk on the roster. This may or may not be a registered nurse, although the facility manager advises that she is trying to ensure all registered nurses have a current first aid certificate.   It is noted during the two days of audit that the general environment is calm and appears well managed with no evidence of residents being rushed, or left unassisted. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare receives referral information from Accessibility (local NASC) which includes relevant assessment and medical information. This information is used to develop individual resident’s files.  Residents admitted to the service have the information relevant to their circumstances recorded on the day of admission as verified in files reviewed (four of four rest home and four of four hospital resident files). The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.   All records sighted are secure. Residents’ files are stored in a locked cupboard in each areas nurse’s station. Resident information is kept in hard copy format. The registered nurse deals with resident’s file content.   The administrator keeps a register of past and present residents in hard copy and on the computer, which includes details of name, NHI, date of birth (DOB), GP and room number plus admission date and address, next of kin (NOK) and date left service (including discharge address) and or deceased. This is then saved and archived when the resident leaves the facility to ensure the register is always up to date. Archived files are in a locked room and easily accessible.  The service is not responsible for NHI numbers.  All relevant ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare provides an environment whereby when the need for service has been identified. It is planned, co-ordinated and delivered in a timely and appropriate manner. Service availability, information, access and entry criteria are documented and communicated to residents and their family / whanau by local doctors, referral agencies, DHB hospital, the Eldernet website, Aged Concern and local community groups. Information includes full details of the services provided, its location, hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.   Prior to entry, the resident must be assessed by Accessibility, the Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure they require the care provided.   If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency. All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Facility Manager or Clinical Manager.  Files reviewed (five of five rest home and four of four hospital) contain completed assessments by the NASC agency verifying placement is required. Admission agreements are signed and sighted in each of the nine files. Admission agreements meet contractual requirements. Residents (four of four rest home and two of two hospital) and family members (eight of eight) interviewed confirm they were informed and involved in this process.  The ARRC contract requirements are met |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| St John’s Hill Healthcare has a clear process for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. The reason for declining entry is documented and kept on file. No residents have been declined entry to St John’s Hill Healthcare since it opened. The admission agreement, describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility.   The ARRC contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Each stage of the service provision is undertaken by a suitably qualified provider and is developed with the resident and their family/whanau. Within 24 hours of admission the initial assessment process is undertaken by the Clinical Manager or Facility Manager (both registered nurses) and includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the resident’s immediate needs. A medical assessment is conducted by the resident’s general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.  Within three weeks of admission the RN (who is allocated as the resident’s key worker) completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the resident’s need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift.  The ongoing assessments, interventions and evaluation is completed and documented by the residents key RN in consultation with the resident, family and allied professionals as resident’s needs change. The care plan is reviewed as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met. There is no evidence of six monthly review sighted in files reviewed as the residents have not been in the facility for six months. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The residents’ medication charts are reviewed three monthly or as needs change and this is conducted by the GP.   Family contact is documented in the family contact record. Evidence of this is sighted in nine of nine files reviewed and verified by interview. Residents and eight of eight family/whanau are happy with the quality of care that is provided as evidenced by interviews.  Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident’s key worker and is responsible for planning, reviewing and overseeing all aspects of the residents care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have qualifications in food safety training. The contracted podiatrist provides services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC. Each RN oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice   A verbal handover between RN’s occurs at the beginning of each shift and she passes the information to the care staff to ensure all staff is familiar with the resident needs. Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required.   The ARRC contract requirements are met.  Tracer methodology one – Hospital Resident  *XXXXXX This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology Two – Rest home resident  *XXXXXX This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Within 24 hours of admission residents' have their needs identified through a variety of information sources that includes the NASC assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested.   Over the next three weeks, the RN undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care and activity planning. The assessments are reviewed as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable.  Evidence of this is sighted in nine of nine files reviewed. Resident and family interviews, verify they are included and informed of all assessment updates and changes. Files reviewed had no residents residing at St John’s Hill Healthcare for longer than six months.  11 of 11 care staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.   The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care plan is developed in consultation with the resident and/or family/whanau. It documents the resident’s individual plan of care identified by initial and on-going individual assessments, and describes the required support to enable the resident to meet their needs, goals and desired outcome. Residents have one set of clinical notes in which all providers involved with the resident’s care use to document the resident’s progress. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, diversional therapist, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan.  Care plans are evaluated as the resident's condition dictates. There is no evidence of six monthly evaluation sighted as files reviewed were of residents who had not been in the service for six months. Short term care plans, document the existence of short term problems and the required intervention.  Information from the assessment process informs the allied services of resident need. The kitchen is informed of need regarding nutrition, activity assessments inform the diversional therapist of interventions required in the activities programme and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included in the planning of their care.   The staff education records sighted demonstrate that staff receive appropriate training. Training records evidence education that includes infection control, Treaty of Waitangi and cultural safety, privacy, code of rights, health and safety, medication management, dementia care, wound care, restraint minimization and safe practice, elder abuse and neglect. The RNs participation in the Professional Development Recognition Programme at the DHB has just been initiated and the RN’s have two monthly discussion sessions over journal articles prescribed to them to read by the manager.   Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. Timely access to other health providers is evident in eight of the residents' files, where specialist input is required.  The ARRC requirements are met. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care and services at St John’s Hills Healthcare are delivered in a safe and respectful manner. The provision of care is consistent with the desired outcomes in residents’ files reviewed which document the residents’ physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.  Interview with the GP verifies satisfaction with the care provided to his residents, staff respond promptly and appropriately to all residents needs and requested medical intervention.   Interviews with residents and family/whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility. There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident’s needs (sighted).  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Two diversional therapists and a diversional therapist assistant is employed at St John’s Hills Healthcare ensuring activities are provided in the rest home and the hospital every day.   On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident’s preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.  Activities reflect ordinary patterns of life and include normal community activities (e.g., bus outings, visiting entertainers, and visits to the local returned services association club, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.   Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the resident’s response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.  A residents meeting is held monthly and meeting minutes evidence that the activities programme is discussed. Residents and family are satisfied with the activities offered. The diversional therapist interviewed reports feedback is sought from residents during and after activities.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.   The RN undertakes and documents all care plan evaluations. Evaluation measures the degree of achievement or response of each resident related to their goals. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan. A short term care plan is initiated for short term concerns such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.  Evidence of evaluation of the resident’s long term care plan is sighted in three of nine files reviewed. However in six of nine files reviewed there is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected. This is an area requiring further improvement.   Resident and family interviews, verify they are included and informed of all care plan updates and changes.  The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Evidence of the RN undertaking and documenting evaluation of the resident’s long term care plan is sighted in three of nine files reviewed. However in six of nine files reviewed there is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected. |
| **Finding:** |
| In six of nine files reviewed there is a lack of documentation informing the degree of response to the documented interventions and there is a lack of evidence of changes being initiated where progress is different from that expected. |
| **Corrective Action:** |
| Show evidence of documented evaluation of the support and/or intervention and documented progress towards meeting the desired outcome of the residents. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident support for access or referral to other health and/or disability service providers is facilitated to meet the residents’ need. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, and where possible a family member accompanies the resident. The facility has access to a van that can escort residents to appointments.   Residents are given a choice of GP when they are admitted. Most residents use the contracted GP. He visits twice weekly and offers a 24 hour/seven day a week service. Acute/urgent referrals are actioned immediately and if the resident’s GP is unavailable after hours the Wanganui DHBs accident and emergency Department will send a doctor to attend to the resident at St John’s Hill Healthcare.   The resident is sent to accident and emergency in an ambulance if the circumstances dictate. Families are informed.   The ARRC requirements are met |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Exit, discharge or transfer is managed in a planned and co-ordinated manner that keeps the resident family/ whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person / facility responsible for the ongoing management of the resident. There is a specific transfer/discharge form that records all the relative information needed when transferring a resident. If the resident is transferring to Wanganui DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes.    The ARRC requirements are met |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The Medication Management Policy is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. There is a documented process in place to manage the reconciliation of medicines, when they arrive from the pharmacy; however there is currently not any evidence available to indicate that this process is being implemented according to requirements. When administering the medication to the residents, the two of two RNs observed checked the medications in the packs against the medication chart.    Medicines for residents are received from the pharmacy in the Robotic delivery system. A safe system for medicine management is observed on the day of audit. All staff who administer medicines have current medication competencies (sighted). The staff observed administering medication demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management. The clinical manager and facility manager monitors to ensure all staff who administer medications have current competencies. RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in “Medication Administration” in the rest home or certified as competent to check controlled drugs (documentation sighted), under the direction and delegation of a RN.  Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks and reconciliation recorded.  The records of temperature for the medicine fridges have readings documenting temperatures within the recommended range   The medicine prescription is signed individually by the GP. The GP’s signature and date are recorded on the commencement and discontinuation of medicines.   Residents’ photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.   There is one resident who self-administers an inhaler at the time of audit. The sighted assessments for self-administration is in the file reviewed and meet the facilities policy.   Medication errors are reported to the clinical manager and facility manager, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in the files reviewed.   Standing orders are used. The written authorisation (sighted), signed by the residents GP, identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly.   The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The Medication Management Policy is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. However, there is currently not any evidence available to indicate that the reconciliation process is being implemented according to requirements. When observing administering the medication to the residents, the two of two RNs observed checked the medications in the packs against the medication chart. |
| **Finding:** |
| There is a documented process in place to manage the reconciliation of medicines, when they arrive from the pharmacy; however, there is currently not any evidence available to indicate that this process is being implemented according to requirements. |
| **Corrective Action:** |
| Demonstrate the implementation of an appropriate process to manage reconciliation of medicines and have documented evidence this is in place. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A food service manual is sighted, and policies and procedures cover food safety, food storage and thawing for example. Staff responsibilities around food and fluid management and mealtime services, which meet recognised guidelines, are also sighted. Daily records of temperatures for six different fridge/freezer, chiller (2-sided) and freezer (3) units are being made, as are records of hot foods and monthly reviews of kitchen hot water. All are within the respective expectations.   The menu is reviewed and shows that the winter menu has a four week rotation, compared with a six week menu in summer. Evidence of menu reviews by a dietitian is sighted for both the summer and winter reviews. The current menu was reviewed 10 March 2014. The cook advises that if a key product is not available one day then a straight swap within the same seven days is undertaken.   A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed, These are evidenced in five of five rest home and four of four hospital files reviewed. Special equipment, to meet resident’s nutritional needs are sighted. Copies of the dietary needs profiles are provided to the kitchen and are sighted in a folder. The profiles include any specific dietary needs, likes and dislikes, any assistance with feeding that may be required and any special equipment. Summaries are written onto a whiteboard in the kitchen. The cook informs during interview that there is a person that requires special considerations for a renal diet and explains how this is done. There are some residents who require a diabetic diet and others who require soft or moulied food. Any thickened fluids and/or fortifies drinks are managed by nursing staff in the wings.   The principles of stock rotation are described and observation of this in practice is made for dry goods, fruit and vegetables, tinned goods and dairy products. All frozen foods have dates on them. Stickers on dry goods state the original expiry date on the product and the date the container was cleaned and decanted. The cook informs leftovers are discarded immediately and fridge items, such as sandwiches, are consumed within two days. There is no evidence of food being held in the fridge beyond 24 hours. Food disposal is via an insinkerator and into black bags that are emptied a minimum of once daily and disposed of via general rubbish in the skip.   There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. The serving of meals in the ground floor dining room is observed and it is noted meals are only dished as they are needed for people who require feeding assistance. One person at a time is assisted with feeding and encouragement is offered in a congenial manner for those who are slower to eat. Three residents and two relatives who are specifically asked about the meals state they have no complaints about the food. There is no evidence of complaints about the meals in the relative or residents’ meeting minutes despite it being an agenda item. The facility manager informs that the service has not been going long enough to send out a survey to residents or residents when food would be a standard question and that meantime they are reliant on verbal feedback. Evidence of resident satisfaction with meals is verified by six of six residents and eight of eight family/whanau interviews and resident meeting minutes.  Cooks and kitchen staff are being assisted with an e-learning package on the circle of safety with attention to infection control and food safety. Certificates are in staff files. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A waste disposal policy is sighted and includes the procedures for use of personal protective equipment. Kitchen waste is emptied into lidded bins and are away from consumables. When applicable, medical waste is to be double bagged and cultural considerations are included. Safe processes for liquid body waste and sputum are clearly defined.  Residents’ rubbish bins are reportedly emptied daily and washed weekly according to the cleaner’s schedule. A contractor is used for the disposal of general rubbish. The rubbish skips are sighted outside by the garage and are emptied weekly. Recycling is undertaken and placed into four wheelie bins that collect plastics, glass, cans and paper. The latter is burnt in a furnace on site and the remainder is taken once a week to the Wanganui depot. Continence products are placed in blue bags, infectious rubbish is placed in double yellow bags and sharps are disposed of in sharps containers that are swapped over when full.   Staff are observed using plastic aprons and plastic gloves, both of which are readily available. A cleaning staff person with a cold is observed wearing a mask. On the first day of audit there is no face shields available in the sluice rooms, although one is found with the pandemic and norovirus kits. By the end of day one of the audit two additional shields have been purchased and are available in both the upstairs and downstairs sluice rooms. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The St Johns Hill Healthcare rest home and hospital is a fully accessible facility with level entrance at the front, wide corridors with handrails, an elevator between ground floor and level one and wet area type showers in communal and ensuite bathrooms. Maintenance is undertaken according to entries in a maintenance book, which is checked daily. It is noted that all entries are dated on completion and each has been addressed within a maximum of two days. A list of local tradesmen in the capacity of preferred providers is sighted.   Hot water temperatures are checked monthly and sit between 42 and 45 degrees. A system of checking these means that different rooms are checked each month on a rotating cycle and temperatures are recorded on both a plan of the facility and on a room number list. Two hydroboil systems in a lounge and dining area are in place. Potential risks of these are noted as one that has a guard does not have it in situ and the other does not have a guard. Between the two days of audit one of these is disabled and the other has a guard placed in situ to prevent any resident form inadvertently turning it on. The external surfaces of hot water radiators are found to be too hot in some areas and a tradesman is called. Staff are alerted to the risk by the facility manager and the owner. A week after the audit the service provider provides a full quality improvement plan on the issue that demonstrates ongoing monitoring is continuing and notes how the service is reducing the likelihood of a recurrence.  An ongoing facility and equipment maintenance checklist has been developed by an engineer who is familiar with aged care facilities and records and reports that are sighted and reviewed show this is being upheld. Records sighted and equipment checks made show that all electrical checks have been made within the past year, all equipment such as sphygmomanometers, hoists and electric beds have been checked and/or calibrated and the receipt for a new set of weighing scales shows it is too early for a check of their calibration to have been made. Review dates are September 2014, or beyond.  According to the owner, this facility was fully refurbished and earthquake strengthened before it opened as St John’s Hill Healthcare in October 2013. The building warrant of fitness is current with an expiry date of June 2015.  Paved courtyard and garden areas with outdoor seats are available for residents’ use. There is a garden area with lawns and fruit trees that is accessible by ramps. All are safe and environmentally pleasant with views down to the river. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Forty four of the total of 56 residents’ rooms have toilet and wet area shower ensuites. There are also four other shared toilets and bathrooms for communal use in addition to separate toilets for resident and public use. All communal toilets and bathrooms are labelled. A sluice room is available to staff on each of the two levels. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All residents have their own room and each is spacious. Residents, including those with mobility aids such as walking frames, inform they are able to move around them easily, and staff inform they have no problem and can use equipment such as hoists and wheelchairs in them with ease. A whanau or visitors room is available for relatives of those receiving palliative care. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A full size chapel from the original Home of Compassion is situated on the ground floor and is used for communal meetings as well as well as church services and some quieter or light musical activities. On both the ground floor and the first floor, there are large communal dining and lounge areas at the end of each main corridor from which the majority of residents’ rooms come off. The general manager informs that most activities sessions are undertaken in these areas. There has been discussion at resident and relative meetings about the possibility of separating the dining and lounge sections, however most reportedly like the added space the current set up provides. A hairdressing room is upstairs and a separate smaller dining area off one end of the upstairs dining/lounge area is able to be separated off for additional privacy, or for a small group function/activity. There are also a small family lounge upstairs, which is referred to as the library. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented linen handling processes provide clear guidelines for staff in the clean / dirty management of laundry items and the requirements around when staff are to use personal protective equipment in the laundry. Similarly a housekeeping policy is sighted and covers expectations of the cleaning staff. Position descriptions for both are sighted.  The laundry, which is purpose built is visited. The main laundry staff person is interviewed and is familiar with infection control precautions and the use of personal protective equipment. The dirty to clean flow is evident, a dispensing system is on place for all chemicals and on the day of audit the process appears orderly and tidy. The laundry person is responsible for all laundry and for all ironing. No laundry items from this facility are outsourced.   The cleaner is also interviewed and is clearly dedicated to her role. She is able to describe safety precautions she needs to be aware of, such as where her trolley is placed, wet floors, and the need for resident care to come first. In addition she knows her task list and informs that all residents’ rooms and ensuites are cleaned daily. On Friday and Saturday the cleaner has a relief person while she undertakes some laundry tasks and the relief cleaner also does all of the cleaning duties on Sunday and Monday, the usual cleaner’s days off.   All bulk chemicals are stored in a locked cupboard in a non-resident area. Other chemicals and the dispensing units are in cleaners’ cupboards, which are situated on both the ground and first floors. The cleaner’s trolley is stored in the cupboard when not in use and chemical data safety sheets are available in each of these rooms. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a detailed health and safety programme that covers all possibilities should any emergency or health and safety event occur. These include management commitment and responsibilities; hazard identification; assessment and management; scheduled health and safety related internal audits; adverse events reports and management; notification and record keeping; hazard register; disaster management and planning; training in lifting and handling competency; employee participation and planning, review and evaluation of health and safety in the workplace. The four key health and safety representatives include the facility manager, the clinical manager, the diversional therapist and the maintenance person. Appropriate definitions of significant harm and notifiable serious hazards are included. The programme covers all persons entering the facility including temporary employees / volunteers and sub-contractors and all aspects are linked back into the quality and risk management system. This service has commenced planning for a joint and cooperative response with the local district health board and plans for this to date are sighted.   All new staff undertake both fire safety and emergency management training as part of their orientation programme and this is evident in the review of ten staff files. Updates on fire and emergency training are required every six months and these have been provided to staff who commenced when the service began in October 2013. Fire warden training has been provided by the company that is responsible for the monthly checks of the fire alarms and fire-fighting systems. Records sighted show these are being maintained. The fire evacuation plan approval letter from the fire service, dated 24 March 2014, is sighted. Fire evacuation trial records for 10 May and 30 June 2014 are sighted. These have been undertaken more frequently than the required six months due to the additional new staff employed as resident numbers have increased. Fire evacuation checklists are at reception and in each nurses’ station.  The boiler is gas fired and the kitchen uses a combination of both gas and electricity for cooking. A generator, which is checked monthly as per the maintenance schedule, kicks in automatically and will power the lift, laundry or kitchen (one area at a time). There are additional blankets in the civil defence cupboard (sighted) should the gas also fail. The general manager and the owner both note that St Johns Hill Healthcare is on the Wanganui City Council priority list for critical care designation in the event of an emergency. Records of this are dated 5 June 2014. An emergency power system covers lighting and one fax machine in the nurses’ station for external communication. An emergency management plan includes photographs of what to turn off and where these valves and switches are. The well-stocked civil defence supply room is checked and holds kits for norovirus and pandemic incidents, as well as emergency supply kits and first aid kits. The contents of each are being checked monthly. A water tank holding 6,000 litres is sighted on site in addition to a large number of 20 litre and three litre bottles in the civil defence cupboards.  A call bell system is operational throughout the facility and is accessible to residents and staff in residents’ rooms, ensuites, bathrooms and communal rooms. It is a system that shows orange lights outside the relevant area when a call bell is rung and digital read outs in the corridors inform of the room number. The light turns to green when a staff person goes into the room and lights red in an emergency. Random checks of operation and response times are undertaken monthly as part of the internal audit system.  To date there have not been any incidents of concern related to security and nightly visits from a security firm have been cancelled. All external doors are able to be locked and unlocked internally from a panel in the nurses’ station and staff on evening and night shifts are responsible for doing security checks. It is reported that there are houses nearby and the Roman Catholic Sisters living behind the facility continue to keep an eye on the facility. Staff are taught to ring the police if they have any concerns and to notify the owners, who live on site most of the time, of any concerns. All windows have security stays (sighted) and there are security lights on the outside of the building. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All residents’ rooms and communal areas have an external window and all such areas have windows that are on security latches but are able to be opened for ventilation purposes. Extractor fan systems are in bathroom areas.  The facility is heated by water filled radiators with the water being heated via gas fired boilers. Heating units are in all resident areas, communal dining and lounge areas and in hallways. The facility is warm and comfortable on what is otherwise a cold day.   There is a designated smoking area at the rear of the building for people who choose to smoke. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures for restraint minimisation and safe practice that meets the standards are in place and are sighted. At stage one audit it is noted that the word ‘cotsides’ is being used in these documents, however by stage two audit the use of this word has been amended to bed rails. The definition of enablers is congruent with the definition as required for the standard with the focus being on the resident choosing and/or agreeing to use it for their safety. Eight staff inform during a group interview of the difference between an enabler and a restraint and this is further endorsed in a discussion with the restraint coordinator, who also describes the assessment and review and monitoring processes.  Two residents are currently using enablers and records sighted in their personal files confirms they have requested use of bed rails at night for their perceived safety needs and to assist them to turn in bed at night. Both have enable use informed consent forms signed by themselves and both have three monthly reviews from the GP confirming they are mentally capable of making this decision. There is also good evidence of nightly monitoring and three monthly reviews occurring.   The restraint reporting section of the quality meeting minutes and interviews with the facility manager, the restraint coordinator and the staff group all note there are not currently any restraints being used in this facility. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the manager to ensure appropriate resources are available for the effective delivery of the infection control programme and it is her responsibility to implement the programme.  The infection control practices are guided by the infection control manual and assistance from the Wanganui DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Reporting lines are clearly defined. The infection control nurse records monthly infection rate data and present a monthly report to the quality meeting and staff meetings. The Facility Manager reports to the organisation’s General Manager any serious infection related issues. The infection control programme is to be reviewed annually and has not yet been reviewed as the service has not been operating for a year. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Clinical Manager and Facility Manager are responsible for infection control at the facility. A position description is included in the infection control (IC) programme and in the clinical manager’s file.  The infection control nurses verify there are enough human, physical and information resources to implement the infection control programme. They take responsibility for implementing the infection control programme and have access to expert advice when required. Infection control training of the infection control nurse occurs via training offered through an external provider. Infection control training for staff was last held on the 26 June 2014 with the last hand washing competency assessed on the 5 November 2013.   The infection control nurses have access to diagnostic records to ensure timely treatment and resolution of infections.   The infection control nurse facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. The IC nurses report to the quality committee and staff meetings any IC issues on monthly basis. IC data is collected monthly and statistics and data is calculated. |

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

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive orientation and ongoing education, relevant to their practice as verified by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.  Resident education occurs in a manner that recognises and meets the residents’ and the families’ communication style, as sighted in the file of a resident with a chest infection and verified by interview.  There has been no recent evidence of Norovirus. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In line with St John’s Hill Healthcare’s IC policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. Incidents of infections are sighted and are low. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a quality improvement meeting every month and a staff meeting every month where the incidents of infection are presented. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. |

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

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

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

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

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

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