Lyndale Rest Home Limited

Current Status: 22 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

Lyndale Rest Home Ltd is a privately owned company that holds a district health board (DHB) contract to provide rest home and dementia level care to a total of 40 residents at Masterton in the Wairarapa. The current contract held is for 12 dementia beds and 29 rest home beds. It also has seven units for supported independent living clients. The rest home service is in a large older style building called the Villa and the dementia service is delivered at the Manor which is a separate building located approximately 100m further down the road. Both services are at full occupancy on the day of audit. The company has added another eight rooms at the Manor and these have been verified at this audit as suitable for dementia level care.

During the audit one area for improvement is identified around formal qualifications and experience of staff in the dementia unit and a plan to address this is now being implemented.

Audit Summary as at 22 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 22 July 2014

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

Organisational Management as at 22 July 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 22 July 2014

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

Safe and Appropriate Environment as at 22 July 2014

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

Restraint Minimisation and Safe Practice as at 22 July 2014

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

Infection Prevention and Control as at 22 July 2014

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

Audit Results as at 22 July 2014

Consumer Rights

An effective compliments/ complaints system is in place with all response timeframes being met with many being exceeded. There have been more compliments than complaints received in the current year and any issues that have been raised are low level and are both resolved satisfactorily.

Care provided to residents at Lyndale Rest Home (Lyndale Villa and Lyndale Manor) is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Lyndale Rest Home does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with residents 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 used by the service and facilitates regular residents' meetings. Lyndale Rest Home encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

Residents are aware of how to make a complaint and of their right to do so. The complaints process ensures issues are managed in a timely manner. All residents and family members interviewed confirm they are aware of the complaints process and have no complaints or concerns.

Organisational Management

Lyndale Rest Home Ltd is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a Quality Assurance Manager and the two registered nurses (RNs).

A comprehensive quality and risk management system is in place. The quality improvement plan includes an annual calendar of internal audit activity which ensures the quality of service delivery is monitored and any issues are addressed. A process in operation where any new quality initiatives are identified by staff is encouraging a culture of continuous improvement. A suite of polices and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and enable quality improvement.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is implemented to maintain staff competence. The staff report feeling well supported by the management team. An area requiring improvement is identified in relation to the need for clinical staff to complete relevant qualifications and gain further experience in the area of dementia care.

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 provided by Lyndale Rest Home contains information on entry criteria, fees payable, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment and Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

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

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

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents. It is evident the medicine management system at Lyndale Manor is capable of supporting the planned increase in capacity.

The menu has been reviewed as meeting nutritional guidelines by a registered dietician, with any special dietary requirements and need for feeding assistance or modified equipment recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

Residents of Lyndale Manor have access to food at all times. Findings as part of the partial provisional audit being undertaken at this time evidences the food services at Lyndale Manor being capable of supporting an increase in service capacity from the present twelve residents to twenty residents.

Safe and Appropriate Environment

Both sites are very well maintained with a homely environment provided. The residents' rooms and the communal areas are spacious, very clean, well ventilated and kept at a comfortable temperature for residents. There are adequate shower and toilet facilities with most rooms having their own ensuites. Attractive and safe outside areas are easily accessed for all residents.

The buildings both have a current building warrant of fitness.

Waste and hazardous substances are safely managed by staff that are trained in these processes.

Emergency procedures are well documented for ease of use and instructions are located in a number of places around the facility. Regular fire drills are held and sprinkler systems are installed in case of fire. There is access to an emergency power generator at both sites. Adequate supplies are stored to manage any civil defence emergencies that may occur with sufficient water and food available.

Restraint Minimisation and Safe Practice

The philosophy of the organisation is that it will be restraint free and that they will manage all behaviour in a way that promotes this. This is reflected in the restraint free environment that the service currently operates. Staff have ongoing training in the management of any challenging behaviours.

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-ordinator sharing the role with the quality manager, reporting directly to the facility manager who reports to the owner.

There is an infection prevention and control programme for which external advice and support is sought if required. An infection control nurse and the quality manager are responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. 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.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Lyndale Rest Home Limited
Certificate name:	Lyndale Rest Home Limited

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit		
Premises audited:	Lyndale Rest Home (52 Cole Street); Lyndale Rest Home (95 Cole Street)		
Services audited:	Rest home care (excluding dementia care); Dementia care		
Dates of audit:	**Start date:**	**End date:**	23 July 2014

Proposed changes to current services (if any):
An increase in the dementia service from 12 – 20 beds.

Total beds occupied across all premises included in the audit on the first day of the audit:	40

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	XXXXXXXX			**Hours**	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52

Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	50	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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 Monday, 18 August 2014

Executive Summary of Audit

General Overview

Lyndale Rest Home Ltd is a privately owned company that holds a district health board (DHB) contract to provide rest home and dementia level care to a total of 40 residents at Masterton in the Wairarapa. The current contract held is for 12 dementia beds and 29 rest home beds. It also has seven units for supported independent living clients. The rest home service is in a large older style building called the Villa and the dementia service is delivered at the Manor which is a separate building located approximately 100m further down the road. Both services are at full occupancy on the day of audit. The company has constructed another eight rooms at the Manor and these have been verified at this audit as suitable. During the audit one area for improvement is identified around formal qualifications and experience of staff in the dementia unit and a plan to address this is now being implemented.

Outcome 1.1: Consumer Rights

An effective compliments/ complaints system is in place with all response timeframes being met with many being exceeded. There have been more compliments than complaints received in the current year and any issues that have been raised are low level and are both resolved satisfactorily.

Care provided to residents at Lyndale Rest Home (Lyndale Villa and Lyndale Manor) is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Lyndale Rest Home does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with residents 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 used by the service and facilitates regular residents' meetings. Lyndale Rest Home encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

Residents are aware of how to make a complaint and of their right to do so. The complaints process ensures issues are managed in a timely manner. All residents and family members interviewed confirm they are aware of the complaints process and have no complaints or concerns.

Outcome 1.2: Organisational Management

Lyndale Rest Home Ltd is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a Quality Assurance Manager and the two registered nurses (RNs).

A comprehensive quality and risk management system is in place. The quality improvement plan includes an annual calendar of internal audit activity which ensures the quality of service delivery is monitored and any issues are addressed. A process in operation where any new quality

initiatives are identified by staff is encouraging a culture of continuous improvement. A suite of polices and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and enable quality improvement.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is implemented to maintain staff competence. The staff report feeling well supported by the management team. An area requiring improvement is identified in relation to the need for clinical staff to complete relevant qualifications and gain further experience in the area of dementia care.

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.

Outcome 1.3: Continuum of Service Delivery

Information provided by Lyndale Rest Home contains information on entry criteria, fees payable, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment and Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

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

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

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents. It is evident the medicine management system at Lyndale Manor is capable of supporting the planned increase in capacity.

The menu has been reviewed as meeting nutritional guidelines by a registered dietician, with any special dietary requirements and need for feeding assistance or modified equipment recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

Residents of Lyndale Manor have access to food at all times. Findings as part of the partial provisional audit being undertaken at this time evidences the food services at Lyndale Manor being capable of supporting an increase in service capacity from the present twelve residents to twenty residents.

Outcome 1.4: Safe and Appropriate Environment

Both sites are very well maintained with a homely environment provided. The residents' rooms and the communal areas are spacious, very clean, well ventilated and kept at a comfortable temperature for residents. There are adequate shower and toilet facilities with most rooms having their own ensuites. Attractive and safe outside areas are easily accessed for all residents.

The buildings both have a current building warrant of fitness.

Waste and hazardous substances are safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and instructions are located in a number of places around the facility. Regular fire drills are held and sprinkler systems are installed in case of fire. There is access to an emergency power generator at both sites. Adequate supplies are stored to manage any civil defence emergencies that may occur with sufficient water and food available.

Outcome 2: Restraint Minimisation and Safe Practice

The philosophy of the organisation is that it will be restraint free and that they will manage all behaviour in a way that promotes this. This is reflected in the restraint free environment that the service currently operates. Staff have ongoing training in the management of any challenging behaviours.

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-ordinator sharing the role with the quality manager, reporting directly to the facility manager who reports to the owner.

There is an infection prevention and control programme for which external advice and support is sought if required. An infection control nurse and the quality manager are responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. 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.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	5	0	0
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 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The RN staff covering the dementia unit have not yet completed their ACE dementia training nor do they currently have enough relevant experience to meet the requirements of the ARC contract.	Clinical RN staff complete the required training in the care of older people with dementia and the aging process and have support to gain more service specific experience.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home (Lyndale Villa and Lyndale Manor) is observed to provide an environment in which residents receive services in accordance with human rights legislation.

Managers interviewed (two of two) and staff (ten of ten) 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 and a copy of the Code at orientation and ongoing education through in-service training as verified in staff records reviewed (seven of seven employment, orientation and training records), planned education programmes, and staff interviews. Residents (five of five rest home residents) and family/whanau (four of four rest home resident family / whanau, and two of two dementia residents family / whanau) interviews and resident satisfaction surveys verify the service complies with consumer rights legislation.

Clinical staff (six of six staff who work in the rest home and two of two who work in the dementia area) are observed to explain procedures being undertaken, seek verbal acknowledgement for a procedure to proceed prior to it being commenced, protect residents' privacy (eg, notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and address residents by a preferred name.

Compliance with the Code is also monitored through sighted resident and relative satisfaction surveys.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home provides an environment in which residents are informed of their rights. Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service with information brochures clearly displayed and accessible to all residents, as sighted.

On admission, residents receive a resident's handbook that outlines services provided, a list of resident's rights and responsibilities at Lyndale Rest Home and a copy of a complaints form.

Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time.

Advice to 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 a residents' advocate who visits weekly, and runs the residents' meetings; however this person has just resigned and a replacement is being sought.

This is verified by staff, residents 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home 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 provides privacy of stored information. Privacy when discussion concerning residents takes place is in residents' rooms. Staff education on 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.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)
Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)
Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home recognises the special relationship between iwi and the Crown and appreciates that 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.

There are no residents who identify as Maori at Lyndale Rest Home at the time of audit.

Local Maori health providers support the facility and present education and advise related to cultural safety.

Staff receive two yearly 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home 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 those resident's specific needs and objectives are met.

An inter-denominational church service is delivered fortnightly, in the Villa, 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.

Evidence to support findings is sighted in resident file reviews and staff training records. Resident and family/whanau interviews and resident satisfaction surveys 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Lyndale Rest Home provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.

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 procedures 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. This is evidenced in staff files 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home 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.

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 orientation and 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.

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. Team Leaders have yearly assessments to determine competency (sighted) to administer and check medications under the direction of the Registered Nurse (RN). RN's and team leaders have up to date first aid certificates (sighted). Ongoing education for RNs is supported by the facility (refer 1.2.8.1) and the Wairarapa District Health Board.

Kitchen staff have NZQA167 qualifications in Safe Food Handling

Residents and relatives interviewed verify satisfaction with the services provided and resident satisfaction surveys undertaken annually indicates overall satisfaction with the service.

An interview with the GP verifies satisfaction with the services provided. The service responds promptly and appropriately to requests and is prompt in requesting input if needed. He is complimentary of the services offered by Lyndale Rest Home.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home provides an environment conducive to effective communication.

Communication with relatives is documented in the residents' progress notes with a stamp highlighting 'contact with family' (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 two yearly 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 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).

On admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about and at what time of day they wish to be notified (documentation sighted).

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, are included in care reviews and receive copies of evaluations if they have requested to do so.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home provides residents and where appropriate their family / whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Legal advice is able to be sought on all documentation prior to it being signed. 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 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 resident's photographs for identification. Resident's choices and decisions are recorded and acted on. A resuscitation directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The resuscitation directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent or non consent to be revoked at any time. Resuscitation 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 their 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 consumer satisfaction survey results (sighted), indicate family/whanau satisfaction with involvement in care.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home recognises and facilitates the right of residents to advocacy / support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner's office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to 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.

Lyndale Rest Home has an independent advocate who visits the facility weekly and will act as the residents advocate if they choose. The advocate runs the quarterly residents' meetings. This person has recently notified the service she is unable to carry out this role any longer so the service is currently seeking a replacement.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home 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. File reviews, manager, RNs and the trainee diversional therapist confirm community services used by the facility include:

- local social groups,

- the local community centre activities

- other aged care facilities

- local church groups and services

- the WDHB nurse specialists

- The local needs assessment and service coordination agency (NASC) Focus.

- the service has a podiatrist who visits regularly

- residents have the GP of their choice

- WDHB outpatient and inpatient services as appropriate.

The ARRC requirements are met

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review:The complaints policy and procedure describes the complaint process in an easily understandable format with diagrammatic representation to support that. The complainant is given feedback within five working days of the manager receiving the form. The complainant is contacted in writing with an explanation that addresses the complaint within ten working days of receipt. Updates as required will be given at least every ten days. Staff and resident confidentiality will be maintained throughout the procedure. If the complainant is not satisfied with the outcome of the complaint, they will be informed of their right to access an independent advocate, provided through the advocacy service, the local DHB or the Health & Disability Commissioner and assisted if necessary.

The complaints register is sighted. Two complaints have been received so far this year and the process used for both follows the organisational policy with required timeframes met. Both complaints are satisfactorily resolved. Five compliments have been received. Feedback to staff occurs as appropriate during regular staff meetings. The manager confirms all complaints are responded to promptly, often well within the timeframes of the policy.

Staff in interview all report they understand the complaints procedure and that the environment is one where complaints are welcome as a part of the process to improve service delivery. They do not hesitate to assist residents who may wish to express concerns.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The organisation is governed by a Board of three which consists of the two owners and the manager. A business and strategic plan for 2013 – 2016 is developed. The strategic goals for the period are detailed and a list of the relevant actions to achieve this is described. The organisation's mission, philosophy and purpose of the business plan are documented. The document was reviewed in November 2013.

The manager has been with the organisation for 20 years. She began with the service as an administrator and moved into the management role after six months. She has completed both caregiver training and care management training. The manager maintains currency with attendance at aged care conferences annually as well as attending relevant business and clinical training and forums.

The manager reports to the owners monthly with details including a general residents update, current occupancy, hazard reports, staffing issues, maintenance, purchasing requirements and any other issues that need to be raised with them. The manager confirms these reports are acknowledged and responded to promptly and any concerns discussed in a timely way.

This governance and management structure will continue should the organisation increase its dementia beds. The increase in numbers will only occur once construction has been fully completed and contracts finalised.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)
The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)
The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

Attainment and Risk: FA

Evidence:

When the manager takes leave, the role is managed in her absence by the quality assurance manager (QAM) who is an experienced aged care manager, and is available to step in as required. RN vacancies are able to be covered by existing staff.

If the dementia service is expanded, a plan is in place to increase RN hours as numbers of residents increase. It is expected this would be a gradual process and new staff will be recruited on an as required basis to provide the required staffing levels.

ARRC requirements are met.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)
During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: A quality and risk management plan describes the process the organisation follows to manage risk and quality improvement. A document control system is in place to review all policies and procedures bi-annually or more frequently if required. An audit schedule and facility review is conducted annually with corrective actions raised if needed. Quality improvement information is gathered through:

General Staff Meetings (Monthly)

Clinical meetings (Weekly)

Team Leaders Meetings (Bi Monthly)

Management Meetings (Quarterly)

Cooks Meetings (Quarterly or as required)

Recreation Meetings (Bi Monthly)

Resident Meetings (Bi Monthly)

Relative Surveys (Annually)

Resident Surveys (Annually)

Staff Surveys (Annually)

Meal Surveys (Annually or as required, seasonal)

Quality Improvement forms

A process to identify risks, analysis and evaluate them is described. An action plan is then implemented to respond to, manage and monitor the risk.

The minutes of staff meetings are sighted and the meeting held on 24 June 2014 follows the set agenda items which includes health and safety, infection prevention and control, internal audits results, quality improvement activity and any policy and procedural updates. Notes from a medication inservice education and monthly reports on incidents and continuous improvement initiatives are included. An update on a falls prevention initiative is discussed with all staff and an innovative system to record all falls by location is introduced. The QAM reports high attendance at staff meetings and all staff are required to read and sign the latest minutes.

The internal audit programme is sighted and it details each audit that is due in which month. The audits are carried out by the coordinator. Results are recorded and analysed with the QAM, and relevant corrective actions are raised then signed off when completed. All findings are presented at staff meetings and discussed with input from staff if improvements are needed.

All audits have a minimum target of 80% compliance with many achieving a higher rate. Surveys, the incident and accidents, and complaints and compliments that occur, all inform the quality system. The manager and QAM both work closely together to monitor quality performance and implement new initiatives. If an area needs to have another audit completed before it is due, this is scheduled.

A quality improvement form is used for all new initiatives which are invited from all staff. These are developed into individual plans to be implemented across the organisation as relevant. Progress reporting is completed at regular intervals and presented to appropriate group meetings.

Annual residents and relative surveys are also analysed and any issues raised incorporated into the quality system for action.

A hazard register, one for each site, identifies the hazard with the level of potential harm recorded, actions to minimise the effect and monitoring of the hazard. Currently the construction work at the Manor is recorded as a significant hazard and is being managed to minimise disruption to the service.

Staff report (ten of ten) they are involved in all quality and risk planning and processes through regular staff communications and meetings.

A document control programme is managed by the QAM and policies are reviewed two yearly, unless a need is identified for an earlier review. All policies are current.

The provider has adequate quality and management systems to support an increase in the dementia service.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The open disclosure policy describes the organisation's requirement that any resident harmed as a result of a mistake or an error is to have the circumstances associated with the event fully and frankly disclosed to them and/or their support person. Information about an event must be given to the resident and/or support person in a timely, open, and honest manner, ideally within 24 hours of the event occurring.

The incident /accident policy states: All staff must be observant about potential hazards and report them to the manager as soon as possible by:

- Reporting all accidents/incidents to the Manager/RN/Team Leader
- Ensure the safety of those involved – including any first aid attention
- Complete an accident/incident form before the end of the duty

The health and safety manual contains relevant details of essential notification where relevant. It also includes policies and procedures for reporting incidents / accidents. Reporting forms are filled in and filed in staff files or on the resident's file. The register is sighted where information on all incidents is filed with a description of the incident, details of injury if relevant, treatment, actions taken and if notification of family's needs to be actioned.

The manager confirms there is regional public health approved equipment on site for all cases that require isolation and the process for notification to authorities is clearly understood. A norovirus outbreak in January 2013 is reported appropriately to the DHB and a process put in place to manage this. Forms for reporting to Occupational Health and Safety (OSH) are available for use as required.

There is monthly analysis of incident / accident reports and this informs the quality improvement planning process. This summary is discussed at clinical, management and staff meetings.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation has a range of documents covering staff recruitment, orientation and on-going education. Staff members working within a professional scope of practice will have their qualifications verified to ensure there are no restrictions on their scope of practice.

All recruitment is currently managed by the manager. The manager reports that when a vacancy occurs, advertising in the local paper occurs. The organisation has links with the local Work and Income office and has good support with suitable candidates being referred from them. An application form is submitted, shortlisting completed and interviews conducted. These are usually done by the manager and the QAM with support from RN's for clinical appointments. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. A copy of the podiatrists registration is kept on site.

Seven of seven staff files reviewed have all the required documentation including reference checks being completed, job descriptions, individual employment contracts, CVs, orientation sheets and current performance appraisals. Also included are training records and certificates for all individuals. Mandatory police vetting is now completed for all new staff.

All newly appointed staff receive a comprehensive orientation. An initial session is held with the coordinator who covers the introduction to the facility, policies and procedures for health and safety, infection prevention and control and staff receive an orientation pack. This has a checklist of all activity required to be completed by the person within

the first two to three weeks of employment. New staff are then paired up with a more experienced staff member for the first four duties. A review is completed, and then as they are able to perform duties, they are given more responsibilities.

All staff interviewed confirm the orientation was completed and they felt competent to carry out their duties as required.

An annual training programme is in place which covers the required training for these services including manual handling, infection prevention and control. A DHB training programme is available for the RN's. ACE training is required to be completed by all care staff and currently 15 staff have completed or are in the process of completing the ACE dementia programme.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Document review: A staffing levels policy gives guidelines as to safe allocations of staff to the number of residents at the facility. The manager and QAM have responsibility to ensure all staffing levels are maintained at levels that will meet the needs of residents at all times. They complete the rosters and manage any absences.

Two RN's are rostered on for four days each to cover both sites. The current roster sighted confirms adequate cover with the number of staff on duty at any one time. All team leaders hold current first aid certificates as do a number of care staff. A number of caregivers and other staff also have first aid qualifications. At least one person on every duty has a current first aid certificate. The dementia service has four care staff who have completed the ACE dementia programme and a further ten are enrolled in the course and are in the process of completing it.

An area requiring improvement is identified to ensure RN staff complete the required training programme in the care of older people with dementia and the aging process and are supported to gain more relevant experience. Once the required training has been completed by the RNs and they have been supported to gain more relevant experience, the organisation will be staffed with suitable personnel to deliver more dementia services. As the dementia service is expanded, a plan is in place to increase RN hours as numbers of residents increase. It is expected this would be a gradual process and new staff will be recruited to ensure staffing levels are consistent with the staffing rationale policy.

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

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

Attainment and Risk: PA Low

Evidence:

The current RN staff in the dementia unit have not yet completed their training in the care of older people with dementia and the aging process. Both are enrolled in the ACE dementia training programme but have not yet completed all components. The RN with clinical responsibility for the unit has had no previous experience in a dementia unit prior to this appointment. The GP reports he has no concerns with the clinical management of the unit and confirms he is contacted as necessary. To address the current shortfall in the required qualifications in the unit, the management are contracting an appropriately qualified person to undertake clinical oversight of the unit and provide supervision and support to current staff until they have completed the training and have had more experience. This is due to commence the week of the audit

Finding:

The RN staff covering the dementia unit have not yet completed their ACE dementia training nor do they currently have enough relevant experience to meet the requirements of the ARC contract.

Corrective Action:

Clinical RN staff complete the required training in the care of older people with dementia and the aging process and have support to gain more service specific experience.

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home receives residents' referral information from Focus (the local NASC) which includes relevant assessment and medical information. This information is used to develop individual resident's files.

On the day of admission and always within 24 hours of admission, residents admitted have the information relevant to their circumstances recorded, as verified in files reviewed. The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.

All records sighted are secure. Residents' current files are stored in locked offices. Archived files of present residents are in a locked filing cabinets, and easily accessible. Archived files of residents no longer at Lyndale are clearly labelled, easily accessible and secure.

The co-ordinator keeps a register of past and present residents which includes details of name, national health index (NHI), date of birth (DOB), GP, admission date, address, next of kin (NOK) and date left service (including discharge address) and/or deceased. This is then saved and archived when a new resident is admitted to ensure the register is always up to date.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)
Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)
All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home provides an environment whereby when the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.

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 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 Focus, (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. Information is sent out or given to prospective residents. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Manager.

Files (four of four rest home and three of three dementia residents) reviewed contain completed assessments by the NASC agency verifying placement is required.

Admission agreements are signed and sighted in each of the files. Admission agreements meet contractual requirements. Admission agreements and consent forms are given to the resident to take away and sign before admission. An admission time is arranged by the RN who does the initial care plan.

Resident and family members 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

Lyndale Rest Home has a clear process for informing residents, their family / whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. If appropriate, an initial contact is made on behalf of the resident / family. The reason for declining entry are documented and kept on file.

The admission agreement describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility.

There have been two residents declined entry to Lyndale Manor for mobility issues, following a period of hospitalisation. Reassessment determined they were not appropriate for the unit. A documented record is kept.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) 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 residents' immediate needs. A medical assessment is conducted by the residents' 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 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 RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every six months, or as needs change, to ensure the appropriate care is provided and the residents' desired outcomes are being met.

Ongoing medical review is undertaken either monthly, or three monthly if the medical practitioner deems the resident to be stable. The GP covers the resident twenty four hours per day, seven days per week. Non urgent queries are dealt with via email and urgent consultations via phone. The resident's medication is reviewed three monthly or as needs change and this is conducted by the GP.

Family contact is documented in the progress notes and highlighted with a 'family contact' stamp. Evidence of this is sighted in files reviewed and verified by interview. Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Registered nurses practicing certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. Caregivers with experience, education and training in aged care and dementia (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 RN's are in the process of completing the ACE dementia training. The RN with clinical responsibility for the dementia unit has no previous experience in dementia. To address the current shortfall in the required qualifications in the dementia unit, management are contracting an appropriately qualified person to undertake clinical oversight (refer 1.2.8.1).

The cooks have qualifications in food safety training. A contracted podiatrist provides service to the residents.

Each RN oversees those residents whose care they are responsible for planning. Residents are attended to by their GP of choice

A verbal handover by the team leaders occurs at the beginning of each shift, with input from the RN, to ensure all staff are familiar with the residents' needs. A handover sheet recording changes, directs the caregivers.

Caregivers are allocated the residents they are to deliver the daily care to, under the guidance of the team leader / RN, and write in the resident's progress notes at the end of each shift. Residents' 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 (wound care, dietitian and continence specialists).

All care staff carry pagers to request prompt assistance from other caregivers when required.

The ARRC contract requirements are met.

Tracer methodology 1 – Rest home Resident

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

Tracer methodology 2 – dementia 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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, behaviour, 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 six monthly 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 files reviewed. Resident and family interviews, verify they are are included and informed of all assessment updates and changes.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The care plan developed in consultation with the resident and/or family/whanau, 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 document the resident's progress. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, trainee diversional therapists, 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 provided. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, handover sheet and the resident's care plan.

Care plans are evaluated six monthly or more frequent as the resident's condition dictates.

Short term care plans, document the existence of short term problems and the required intervention for up to a month, at which time if the problem still exists, it is transferred to a long term plan specific to the problem.

Information from the assessment process informs the allied services of resident need. The kitchen is informed of need regarding nutrition, activity assessments inform the trainee diversional therapists 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 are included in the planning of their care.

The staff education records sighted for seven of seven staff demonstrate that staff receive appropriate training. Training records evidence education that includes informed consent, infection control, resident rights, advocacy, independence, diabetes, continence, dementia, skin care, spirituality and abuse and neglect. The RNs also participate in education sessions presented by the DHB.

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 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The care and services at Lyndale Rest Home 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.

An interview with the GP verifies satisfaction with the services provided by staff at Lyndale Rest Home.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are two trainee diversional therapists and an activities assistant employed at Lyndale Rest Home to undertake the planned activities programmes. The trainee diversional therapist, who has recently commenced working in the dementia unit, has formal qualifications in caring for people with dementia (Level four National Certificate in Support of the Older person) and is supported in her role in the dementia unit by a qualified diversional therapist. A second trainee diversional therapist assists in the rest home programme and supports the activities assistant.

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 (eg, van outings, visiting entertainers, 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 six monthly with a monthly summary of the resident's response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.

A residents meeting is held four times per year, and meeting minutes evidence that the activities programme is discussed. The yearly resident / relative satisfaction survey also captures feedback on the activities programme.

The trainee diversional therapist interviewed reports feedback and observed responses about activities from residents and families is documented during and after activities. Residents and their family / whanau are satisfied with the activities offered.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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.

Formal care plan evaluations are conducted at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. 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.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews, verify they are are included, receive a copy of evaluations if they desire and are 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

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 staff member or 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 weekly and offers a 24 hour/seven day a week service.

Acute/urgent referrals are actioned immediately, sending the resident 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

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 yellow transfer envelope. The front of the envelope identifies what is required by the DHB and what is to be included in the envelope to accompany the resident. The back of the envelope identifies what the resident requires from the DHB when the resident is discharged.

If the resident is transferring to a DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes.

The 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

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.

Medicines for residents are received from the pharmacy in the Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All care staff who administer medicines have current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management.

Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.

The records of temperature for the medicine fridge 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. A previous corrective action around medications not being reviewed three monthly by the GP has been addressed and 14 out of 14 medication charts reviewed at audit have documented three monthly medication reviews by the GP.

There are no residents who self administer their medicines at the time of audit. A previous corrective action request to implement a process to facilitate residents to self administer medications safely has been addressed and is sighted.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in the nine of nine files reviewed.

The co-ordinator monitors to ensure all staff who administer medications have current competencies. Team leaders are assessed for medication competency yearly under the direction and delegation of a RN.

Standing orders are used. The written authorisation (sighted), signed by the resident's 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.

Partial provisional audit findings, evidence a medicine management system in Lyndale Manor that is able to support an additional eight residents.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food, fluid and nutritional requirements of the residents at Lyndale Rest Home are provided in line with recognised nutritional guidelines for older people as verified by the dieticians documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook is trained in food and hygiene safety. A cleaning schedule is sighted, as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements.

Between meal snacks are available at all times in the dementia unit, as sighted and verified by resident, staff and family/whanau interview,

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs is sighted.

Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews (sighted satisfaction surveys and resident meeting minutes).

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed (sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience.

Food is ordered by the coordinator on a weekly basis. Fruit and vegetables are ordered twice weekly depending on need and availability and meats and fish are ordered as required. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date / time / contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

Partial provisional audit findings evidence the food, fluid and nutritional needs of an additional eight residents in Lyndale Manor are able to be supported by the systems in place.

A resident's family interviewed made reference to an extra eight residents in the dining room may be noisy, depending on the type of resident. The possibility of this has been considered by management with the option of a second dining room being available if this situation eventuates.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The medical waste policy states that all waste is disposed in accordance with infection control practices in order to minimise the risk of contamination through unnecessary exposure. Staff receive appropriate training in regard of waste collection, spillage, transport and storage through orientation. It gives the organisations policy for hazardous waste including sharps, bodily fluids, as well as non-hazardous waste, soiled linen and the transportation and storage of waste. A storage of chemicals and hazardous substances section is included in the health and safety manual and this describes policy and procedures for the use and storage of these. All hazardous waste and substances are recorded with a flow chart on the management process. A hazardous substance register is kept. The infection prevention and control manual includes protocols for spills of bodily substances and additional information around the management of waste.

The process for the disposal is clearly documented and is observed to be followed by care staff on duty on the days of audit. Both sites have a sluice facility however due to construction work being carried out, all waste items from the Manor are transported to the Villa in plastic containers for management there.

The orientation process includes a module on the safe use of chemicals and management of waste substances. The linen trolleys have a double plastic bag system for collection and disposal of continence products.

A contracted agency supplies all chemical and cleaning products. They provide regular training and maintain supplies and update information. An outside locked cupboard is used to store cleaning supplies. Cleaning products are all colour coded for ease of identification.

Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved, the laundry and the cleaning stores. Staff are observed using these throughout both sites as appropriate during the audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: A transportation of subsidised residents guides all staff in the provision of safe and risk free transportation between health and disability services, outings, community activities including the use of private motor vehicles. All vehicles used for resident transport must have current registration and Warrant of fitness. In the event that wheelchair modifications are made to the vehicle, these will be certified by the Land Transport Authority. Staff are provided with safety training and must have current driver's licences. The organisation has a van that is used for outings for residents.

Current building warrents of fitness (WOFs) are sighted at both sites. They have an expiry date of 30 June 2015.

Calibrations and servicing of medical equipment is done annually with the most recent having been completed in July 2014. Maintenance checks are carried out monthly by the coordinator and records of any repairs needed are kept in the register. These have all been completed in a timely way. Regular temperature monitoring of hot water is done by the coordinator and records kept. The QAM confirms this process is monitored and audited.

The passage ways are clear of any clutter and residents are observed moving freely with walkers and wheelchairs.

Both sites have a safe physical environment with easy access with ramps into a number of outside areas which provide a safe and attractive and well maintained outside garden areas for residents.

Handrails are placed at regulation heights and promote independent mobility.

The new extension being completed at the Manor is purpose built with wide corridors and a secure outside area. There is one area opposite the entrance that has yet to be fitted with an appropriate handrail, however the manager is aware this needs installing prior to completion of the construction work.

ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The large majority of residents rooms have their own en suite bathrooms. The Manor has only one room that does not have its own bathroom and toilet area and at the Villa there are four rooms without ensuites. All these rooms have access to bathrooms that are shared with only one other person. All the bathroom areas are observed to be spacious, clean and hygienic, are well maintained with privacy locks on all shared doors to ensure privacy. A number of visitor and staff toilets are available at both sites. All bathroom and toilet areas outside individual rooms are well labelled.

Hand sanitizers are sighted in all areas of both sites including at the front entrances.

The new areas under construction at the Manor exceed the minimum compliance standards for accessibility and are very spacious and modern.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The majority of the rooms at the Villa are spacious single rooms with ample room for furniture and any other personal belongings the resident has chosen to bring. The rooms at the Manor are all very spacious and all rooms at both sites are kept clean and are tidily presented. Rooms have the resident's name clearly displayed on the door with many having personalised identifying phrases for their rooms. There is ample space for storage of personal mobility aids as needed. Most rooms are able to accommodate hoists if required and all transport areas are observed to be free of barriers to impede movement of residents who use aids.

Two residents spoken with are very happy with their personal spaces and confirm they are warm and always kept clean and tidy.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

The Villa has two lounge areas and two dining rooms to cater for its rest home residents. The lounges are furnished with plenty of comfortable seating and flat screen televisions. Activities are mainly provided in the larger lounge, however there are a number of independent activities available in the other lounge area. Two dining rooms, one at each end of the facility provide small tables with up to five seated at each one. One dining room has its own kitchen space available for residents use if they wish. The Manor has two lounges with another under construction. One large dining room enables residents to have the assistance and supervision as they need it.

ARRC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The laundry policy and guidelines in place detail what needs to be done to ensure safe and hygienic laundry systems are followed. These are used in conjunction with other policies in the health and safety manual which describe the cleaning plans and the storage of relevant chemicals and detergents. A hazard register is also displayed in the laundry along with data sheets of all products in use.

The maintenance and supply of detergents is managed by a contracted company. The chemicals are all colour coded and well labelled.

The person with responsibility for laundry and cleaning confirms regular training is provided and any problems that occur with the machines are promptly responded to. The laundry has the required doors for dirty and clean laundry with well-marked areas for management of this. The process is observed on the day of audit with the soiled laundry arriving in colour coded laundry bags to separate soiled, towels, linen and personal laundry. Any soiled laundry has been through the sluice room process prior to being cleaned. A large washing machine is used to do the different laundry types separately with the automatic dispenser in use. A large dryer is in action and the clean linen is folded and stored in the clean area ready for relocation back to the storage rooms. Residents' laundry is sorted into each resident's labelled area once it has been washed and dried. The person managing the laundry is observed wearing protective clothing and is able to describe her process for ensuring safe and hygienic operation of the laundry. The area is clean and neatly kept.

Internal audits are done on a regular cycle to monitor effectiveness with results being used to ensure standards are maintained.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The Health and Safety Manual describes the facility policy for security of residents, dealing with malicious calls, visitor safety, and health and safety training for all staff in emergency procedures. All staff have health and safety training during orientation and fire drills and evacuation training is held at both sites six monthly for all staff.

The emergency planning folder has policies / procedures and guidelines for emergency planning, preparation and response in the event of fire, earthquake, high winds, flooding, power failures, intruders, unwelcome visitors and what to do if a resident goes missing. There are disaster planning guides which direct the facility in their preparation for disasters and describe the procedures to be followed for fire evacuations and regular practices. There is a list of what supplies are in the emergency packs that are stored at each site.

An approved evacuation plan is sighted dated 23 March 2012.

Both sites have emergency water supplies which are also able to operate a limited number of showers and toilets. They both have generators to run emergency lighting and power for essential services such as the freezers and fridges. Food stocks are kept on site for a minimum three to five days and emergency kits are stocked with torches, wind up radios, mobile phone chargers, glow sticks, fire blankets, and personal supplies.

Call bell systems are in use that is connected to the nurses stations. During the days of audit these are observed to be answered promptly. All staff have two way radios if they do require assistance with residents. This does seem to be effective and reduces the need to use the call system.

A security camera operates at both the Villa and the Manor and an emergency call button is connected to the Armourguard service. All overnight staff wear the call button at all times during the night.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

Both sites have a good natural lighting with all rooms having external windows. The heating is a combination of night store heating and heat pumps. There are heat pumps installed in communal areas. As the audit is conducted during winter the heating is in action and the environment is observed to be warm and comfortable.

ARRC requirement is met.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Document review: The restraint/enabler policy states that the overarching philosophy of the organisation is that it will be a restraint free environment and that they will manage all behaviour in a way that promotes this. There are clear definitions on what an enabler is and what constitutes restraint. There is a section on de-escalation and alternatives to the use of restraint which staff are familiar with. In interview the manager and QAM confirm there is currently no use of any enablers or restraints in either service.

A restraint officer is appointed. The organisation does have a process and the relevant risk questionnaire, assessment, review and monitoring forms should any episodes of restraint use occur. Staff have training in the management of challenging behaviours and de-escalation techniques.

Care staff (seven of seven) report they have never used any form of restraint and are clear on a process should a need ever occur. They also confirm training in challenging behaviour is a part of their regular programme.

ARRC requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Doc review: The infection control policy states:' The purpose of infection control is to limit the acquisition and spread of pathogenic micro-organism by using scientifically based knowledge and thorough planning, surveillance, education and research as part of the overall policy of achieving good quality health care'. The infection control programme is developed in consultation with relevant key stakeholders, (microbiologist, registered nurses and other health professionals). Management, including the infection control coordinator, approve the programme.

A detailed suite of procedures are included in the manual with infection control guidelines for the management of any infectious diseases. Documentation is provided to support staff in all areas of infection control and this is managed by an appointed infection control coordinator. Procedures for management of spills and accidents, standard precaution information including hand washing techniques and the use of protective clothing are all described in detail. Policy for blood accidents, medical waste, spills and immunisations, pandemic planning and notifiable diseases are included.

All incidents and accidents are recorded and the data is used to inform the quality and risk programme.

Lyndale Rest home provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the manager to ensure appropriate resources are available for the effective delivery of the infection control programme (sighted, and confirmed by interview with the infection control nurse) and it is the responsibility of the Infection Control Nurse and Quality Assurance Manager to implement the programme.

The infection control practices are guided by the infection control manual and assistance from the 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, and this is evidenced in observation of practices at audit Reporting lines are clearly defined. The infection control nurse records monthly infection rate data, as evidenced in file reviews and infection records, and present a monthly report to the management meeting and staff meetings (minutes sighted).

It is evident the infection control management at Lyndale Rest home is capable of supporting the planned increase in resident capacity at Lyndale Manor. The infection control programme is reviewed annually and was last reviewed in February 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The quality assurance manager and registered nurse are responsible for infection control at the facility. A position description is included in the Infection Control (IC) programme and in the RN's file.

The infection control nurses verify there are enough human, physical and information resources to implement the infection control programme. They take responsibility for implementing the infection control programme and have access to expert advice when required. Infection control training of the infection control nurses occurs via training offered by the DHB.

The infection control nurses have access to diagnostic records to ensure timely treatment and resolution of infections.

The infection control nurses facilitate the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. Any IC concerns are reported at the management meeting. The IC nurses report to the management 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Lyndale Rest Home has an infection control (IC) programme that is reviewed annually, and includes policies and procedures. These cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the manager as current.

Staffs interviewed, are able to describe the requirements of standard precautions and are familiar with 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

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.

Lyndale Rest Home last had a Norovirus outbreak in January 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

In line with the facility'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 staff meeting every month where the incidents of infection are presented. A yearly comparison based on previous incidents are used as a comparison if required. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. Graphs of infection data is sighted and located in the nurses stations.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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