

# Annie Brydon Complex 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

Annie Brydon Complex and Te Mahana Rest Home provide residential care for up to 87 residents at two facilities. Annie Brydon Complex provides residential accommodation for up to 68 residents who require hospital and rest home level care and occupancy on day one at Annie Brydon Complex was 67. Te Mahana Rest Home provides rest home care for up to 19 rest home residents and occupancy was 18. Both facilities are operated by Annie Brydon Complex Limited. Two areas were identified as requiring improvement at both facilities. The improvements relate to documentation of corrective action plans to address areas identified as requiring improvement and to assessments of residents. Residents and family interviewed at both facilities provide positive feedback on the care provided. A new clinical nurse leader has been appointed at Annie Brydon Complex Limited since the last audit.

## 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

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

#### Consumer Rights as at 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

#### 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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the complaints processes and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents' and their families on admission to each of the facilities. Residents and family members interviewed at both Annie Brydon Complex and Te Mahana Rest Home confirm their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights and the facility's processes if these are not met.

During interview residents and family at both facilities confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and they are fully informed. Advocates are available for residents and one of these advocates was interviewed during this audit and confirmed the residents advise them they are well looked after and that their rights are respected.

The manager at each facility is responsible for management of complaints and a complaints register is maintained at both Annie Brydon Complex and Te Mahana Rest Home. The residents can use the complaints forms or raise issues at the residents' meetings at both facilities.

### Organisational Management

Annie Brydon Complex Limited is the governing body and is responsible for the service provided at Annie Brydon Complex in Hawera and at Te Mahana Rest Home (Te Mahana) in Patea. A range of key planning documents are reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at both facilities, including regular monthly reporting by the managers to the directors.

One of the directors, who is a registered nurse, is the manager at Annie Brydon Complex and they are supported by a recently appointed clinical nurse leader who is also a registered nurse. Te Mahana is managed by a non-clinical manager who is supported by the manager/registered nurse from Annie Brydon Complex as well as by the other directors who each have designated areas of responsibility and work on site at Annie Brydon Complex.

There is evidence that quality improvement data is collected, collated, and analysed to identify trends and that this information is reported to staff and the directors. There is an internal audit

programme in place. Corrective action plans developed following internal audits need to be improved as they do not provide evidence that action plans are developed and implemented to address all shortfalls identified. Adverse events were documented on accident/incident forms and there is evidence of notification to families following adverse events or changes in a resident's condition.

There are policies and procedures on human resources management and the validation of current annual practising certificates for all health professionals is occurring. There is evidence available indicating an in-service education programme is provided for staff at both facilities at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) education modules. Staff records reviewed provided evidence that human resources processes were followed and included but were not limited to reference checking, criminal history vetting and individual education records were maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The clinical nurse leader at Annie Brydon Complex is on call after hours and the manager at Te Mahana is on call after hours. All care staff interviewed at both facilities reported there is adequate staff available.

Resident information is entered into a register at both facilities in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

### **Continuum of Service Delivery**

The Annie Brydon Complex and the Te Mahana Rest Home have documented entry criteria which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with resident and/or family input, is provided within stated timeframes and is coordinated to promote continuity of service delivery.

Staff training records detail appropriate qualifications and/or experience and staff interviewed confirm they are trained and in their view competent to perform expected tasks.

Residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices.

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that interventions noted in their service delivery plan are consistent with meeting their needs.

A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the long term care plan or developing a short term care plan.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.

Medication systems evidence compliance with respective legislation, regulations and guidelines. Policies and procedures detail service provider's responsibilities. Staff responsible for medicine management has attended in-service education for medication management and have current medication competencies. Appropriate systems are documented and implemented for residents who self-administer medicines.

The food service is provided by on site staff at both facilities. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis. There was positive feedback from residents about the food service.

There are areas requiring improvement that relate to providing evidence of a registered nurse involvement in residents' assessments at the Annie Brydon Complex and support needs assessment for a resident with high needs at the Te Mahana Rest Home.

### **Safe and Appropriate Environment**

With the exception of two double bedrooms in the hospital at Annie Brydon Complex, all bedrooms at both facilities provide single accommodation. All bedrooms have wash hand basins and several of the bedrooms at Annie Brydon Complex have ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms at Annie Brydon Complex are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. The bedrooms at Te Mahana are smaller but are large enough to allow for safe movement within the room. There are separate lounges and dining areas throughout both facilities. External areas are available for sitting and shade is provided. Appropriate call bell systems are available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and used by staff.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environments are safe and that the facilities are fit for their purpose. All laundry is washed on site at both facilities and the cleaning and laundry systems included appropriate monitoring systems to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

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

There are twelve restraints and three enablers utilised by residents at Annie Brydon Complex and one restraint used at the Te Manaha Rest Home.

Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are the least restrictive. The service has processes in place for determining restraint approval and restraint processes.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed and each episode of restraint is being evaluated.

Staff interviews and staff records evidence that staff have received training on challenging behaviour and restraint management and have current restraint competency assessments.

### **Infection Prevention and Control**

The Infection Prevention and Control (IC) Programme includes goals for the prevention and minimisation of infection and cross infection, contains all requirements in the standard with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is annual on-going education available for all staff.

Infection control is a standard agenda item at staff and quality meetings. Staff interviewed was familiar with infection control measures at facility.

Surveillance for residents who develop infection is occurring and this is collated monthly.

# 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

<b>Legal entity name:</b>	Annie Brydon Complex Limited
<b>Certificate name:</b>	Annie Brydon Complex Limited
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Annie Brydon Resthome and Hospital; Te Mahana Resthome
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 22 July 2014 <b>End date:</b> 24 July 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	85

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	24	<b>Hours off site</b>	12
<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	24	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	48	Total audit hours off site	23	Total audit hours	71
Number of residents interviewed	10	Number of staff interviewed	18	Number of managers interviewed	7
Number of residents' records reviewed	14	Number of staff records reviewed	13	Total number of managers (headcount)	7
Number of medication records reviewed	30	Total number of staff (headcount)	75	Number of relatives interviewed	11
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	2

## Declaration

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

I confirm that:

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

Dated Thursday, 31 July 2014

## Executive Summary of Audit

### General Overview

Annie Brydon Complex and Te Mahana Rest Home provide residential care for up to 87 residents at two facilities. Annie Brydon Complex provides residential accommodation for up to 68 residents who require hospital and rest home level care and occupancy on day one at Annie Brydon Complex was 67. Te Mahana Rest Home provides rest home care for up to 19 rest home residents and occupancy was 18. Both facilities are operated by Annie Brydon Complex Limited. Two areas were identified as requiring improvement at both facilities. The improvements relate to documentation of corrective action plans to address areas identified as requiring improvement and to assessments of residents. Residents and family interviewed at both facilities provide positive feedback on the care provided. A new clinical nurse leader has been appointed at Annie Brydon Complex Limited since the last audit.

### Outcome 1.1: Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the complaints processes and the Nationwide Health and Disability Advocacy Service, is accessible and is brought to the attention of residents' and their families on admission to each of the facilities. Residents and family members interviewed at both Annie Brydon Complex and Te Mahana Rest Home confirm their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights and the facility's processes if these are not met.

During interview residents and family at both facilities confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and they are fully informed. Advocates are available for residents and one of these advocates was interviewed during this audit and confirmed the residents advise them they are well looked after and that their rights are respected.

The manager at each facility is responsible for management of complaints and a complaints register is maintained at both Annie Brydon Complex and Te Mahana Rest Home. The residents can use the complaints forms or raise issues at the residents' meetings at both facilities.

### Outcome 1.2: Organisational Management

Annie Brydon Complex Limited is the governing body and is responsible for the service provided at Annie Brydon Complex in Hawera and at Te Mahana Rest Home (Te Mahana) in Patea. A range of key planning documents are reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at both facilities, including regular monthly reporting by the managers to the directors.

One of the directors, who is a registered nurse, is the manager at Annie Brydon Complex and they are supported by a recently appointed clinical nurse leader who is also a registered nurse. Te Mahana is managed by a non-clinical manager who is supported by the manager/registered nurse from Annie Brydon Complex as well as by the other directors who each have designated areas of responsibility and work on site at Annie Brydon Complex.

There is evidence that quality improvement data is collected, collated, and analysed to identify trends and that this information is reported to staff and the directors. There is an internal audit programme in place. Corrective action plans developed following internal audits need to be improved as they do not provide evidence that action plans are developed and implemented to address all shortfalls identified. Adverse events were documented on accident/incident forms and there is evidence of notification to families following adverse events or changes in a resident's condition.

There are policies and procedures on human resources management and the validation of current annual practising certificates for all health professionals is occurring. There is evidence available indicating an in-service education programme is provided for staff at both facilities at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) education modules. Staff records reviewed provided evidence that human resources processes were followed and included but were not limited to reference checking, criminal history vetting and individual education records were maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The clinical nurse leader at Annie Brydon Complex is on call after hours and the manager at Te Mahana is on call after hours. All care staff interviewed at both facilities reported there is adequate staff available.

Resident information is entered into a register at both facilities in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

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

The Annie Brydon Complex and the Te Mahana Rest Home have documented entry criteria which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with resident and/or family input, is provided within stated timeframes and is coordinated to promote continuity of service delivery.

Staff training records detail appropriate qualifications and/or experience and staff interviewed confirm they are trained and in their view competent to perform expected tasks.

Residents and family interviewed confirm their input into care planning and access to a typical range of life experiences and choices.

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that interventions noted in their service delivery plan are consistent with meeting their needs.

A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the long term care plan or developing a short term care plan.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.

A visual inspection of the medication systems evidence compliance with respective legislation, regulations and guidelines. Policies and procedures detail service provider's responsibilities. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies. Appropriate systems are documented and implemented for residents who self-administer medicines.

The food service is provided by on site staff at both facilities. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis. There was positive feedback from residents about the food service.

There are areas requiring improvement that relate to providing evidence of a registered nurse involvement in residents' assessments at the Annie Brydon Complex and support needs assessment for a resident with high needs at the Te Mahana Rest Home.

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

With the exception of two double bedrooms in the hospital at Annie Brydon Complex, all bedrooms at both facilities provide single accommodation. All bedrooms have wash hand basins and several of the bedrooms at Annie Brydon Complex have ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms at Annie Brydon Complex are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. The bedrooms at Te Mahana are smaller but are large enough to allow for safe movement within the room. There are separate lounges and dining areas throughout both facilities. External areas are available for sitting and shade is provided. Appropriate call bell systems are available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and used by staff.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environments are safe and that the facilities are fit for their purpose. All laundry is washed on site at both facilities and the cleaning and laundry systems included appropriate monitoring systems to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

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

There are 12 restraints and three enablers utilised by residents at Annie Brydon Complex and one restraint used at the Te Manaha Rest Home.

Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are the least restrictive. The service has processes in place for determining restraint approval and restraint processes.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed and each episode of restraint is being evaluated.

Staff interviews and staff records evidence that staff have received training on challenging behaviour and restraint management and have current restraint competency assessments.

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

The Infection Prevention and Control (IC) Programme includes goals for the prevention and minimisation of infection and cross infection, contains all requirements in the standard with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is annual on-going education available for all staff.

Infection control is a standard agenda item at staff and quality meetings. Staff interviewed were familiar with infection control measures at facility.

Surveillance for residents who develop infection is occurring and this is collated monthly.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	48	0	2	0	0	0
<b>Criteria</b>	0	99	0	2	0	0	0

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

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective actions that are documented following internal audits at Annie Brydon Complex and Te Mahana Rest Home are vague and do not clearly describe the corrective action required to address any shortfalls that are identified during the internal audit. The corrective action/s do not identify the person responsible for implementing the corrective action/s, do not have a timeframe for implementing the corrective action/s and do not provide evidence the corrective action plan/s has been implemented,	Provide documented evidence that (i) corrective action plans are developed, implemented, monitored and signed off as being completed that addresses all areas identified as requiring improvement in internal audits; (ii) the person/s responsible for implementing the corrective action and the timeframes for implementation are documented.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				monitored and signed off as having been completed.		
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The residents' clinical files reviewed at the Annie Brydon Complex evidence the residents' assessments are conducted by an enrolled nurse and not signed off by the RN. A resident requiring a high level of care at the Te Mahana Rest Home requires a current NASC assessment.	i) Provide evidence the residents' assessments are conducted as per the DHB contract (D 16.2b and D 17.3e) at the Annie Brydon Complex. ii) Provide evidence of a NASC reassessment for a resident requiring a high level of care at the Te Mahana Rest Home.	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:**

Staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code of Rights) at least annually (records sighted). Care staff are observed at both Annie Brydon Complex (Annie Brydon) and Te Mahana Rest Home (Te Mahana) interacting respectfully and communicating appropriately with residents. Staff support to residents to make choices demonstrating their knowledge of residents' rights.

Residents (two hospital and six rest home at Annie Brydon and four rest home at Te Mahana) and family members (five hospital and three rest home at Annie Brydon and three at Te Mahana) are able to verify that services are provided with dignity and respect at all times, privacy is maintained and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey results.

Interviews with staff (one registered nurse / clinical nurse leader, one registered nurse, one enrolled nurse, three care givers and two activities co-coordinators at Annie Brydon and one registered nurse and two caregivers at Te Mahana) demonstrate an understanding of resident rights. Education records reviewed at both facilities indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided in October 2013 and August 2013 at Annie Brydon and Te Mahana respectively.

The district health board contract 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:**

The Code of Rights and information on the advocacy service are displayed at both facilities and are available for residents and their family. This information is also provided in the information pack which is provided on admission to the facility.

Residents and family members interviewed at both Annie Brydon and Te Mahana confirm they are provided with information regarding the Code of Rights and the Nationwide Health and Disability Advocacy Service in the facility's admission package, which are reviewed, prior to the resident's admission to either of the two facilities. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.

The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement and 14 admission / service agreements (nine at Annie Brydon and five at Te Mahana) are reviewed and all are found to contain this level of information.

Residents interviewed confirm they have access to an independent advocate if needed. Resident meetings minutes reviewed at Te Mahana indicates discussion on the Code of Rights was led by the independent advocate in April and May 2014. This advocate is interviewed during the audit and confirms their role as an independent advocate.

The district health board contract 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:**

Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents at Annie Brydon (two hospital and six rest home) and Te Mahana (four) and family members (five hospital and three rest home) at Annie Brydon and at Te Mahana (three) and during review of resident satisfaction surveys at both facilities.

Staff receive training on abuse / neglect and the last education session was provided in October 2013 at Annie Brydon and as part of the Code of Rights education in August 2013 at Te Mahana. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents.

Activities in the community are encouraged and several residents attend community events independently. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.

Values, beliefs and cultural aspects of care are recorded in residents' clinical files reviewed at Annie Brydon (four hospital and five rest home) and at Te Mahana (five).

The district health board contract 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:**

The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).

There are two residents at Annie Brydon and three at Te Mahana who identify as Māori and one file at each facility is reviewed during this audit. Access to Māori support and advocacy services is available if required via family members of residents and from Kuia and Kaumatua from the different local iwi. A list of contacts for the various iwi groups is maintained and is reviewed. One of the Kaumatua is interviewed at Te Mahana and describes their input.

A family member is interviewed and confirms their involvement in the care of their family member. Interview of one resident and family member confirms their cultural values and beliefs are met.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. A cultural safety competency is completed by all staff and are sighted on staff files reviewed (nine at Annie Brydon and four at Te Mahana). Cultural safety education was last provided in May 2014 at Annie Brydon and July 2014 at Te Mahana.

The district health board contract requirements 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:**

Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation reviewed lists the details on how to access appropriate expertise (e.g. cultural specialists, and interpreters).

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whānau contact details. All residents have a cultural assessment completed as part of the care planning process.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the resident/relative satisfaction surveys which are completed monthly to a random sample. Church services are held on site on a regular basis as part of the activities programme.

Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The district health board contract 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:**

There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a code of conduct that includes house rules. These documents also address any conflict of interest issues including but not limited to the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on staff files (nine at Annie Brydon and four at Te Mahana).

A review of the accident/incident reporting system, complaints register and interview of the managers at both Annie Brydon and Te Mahana indicates there have been no allegations made against staff alleging unacceptable behaviour.

Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.

### **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:**

Systems are in place to ensure staff receive a range of opportunities which promote good practice within each of the two facilities. Documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.

Education is provided by specialist educators as part of the in-service education programmes and this is confirmed during review of education records, interviews of the managers at each facility, the quality manager, the clinical nurse leader at Annie Brydon, registered nurses (one at Annie Brydon and one at Te Mahana) and an enrolled nurse at Annie Brydon who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The managers and clinical nurse leader advise the district health board (DHB) specialist nurses provide education and support for the clinical staff as needed. The managers also advise that the registered nurses (RNs) and enrolled nurses (ENs) attend education at the DHB and that the RNs and ENs at Annie Brydon are completing the professional development recognition programme (PDRP) via the DHB.

Staff interviewed confirm understanding of professional boundaries and practice.

The district health board contract 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:

Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed as part of this audit. Residents' files reviewed at both facilities (nine at Annie Brydon and five at Te Mahana) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.

The facility managers advise access to interpreter services is available if required via the local community, family members and interpreter services if required. They also advise there are no residents currently in either facility who require interpreter services.

The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements (nine at Annie Brydon and five at Te Mahana) are reviewed and this was clearly communicated in each agreement.

The district health board contract 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:**

Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The facility managers, clinical nurse leader, RNs and EN report informed consent is discussed and is recorded at the time the resident is admitted to the facility.

Residents/family are provided with various consent forms on admission for completion as appropriate and are reviewed on resident's files (nine at Annie Brydon and five at Te Mahana). Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident's files.

Staff interviewed (five care givers, three RNs, one EN, the facility managers and the clinical nurse leader) demonstrate a good understanding of informed consent processes.

Residents (eight at Annie Brydon and four at Te Mahana) and family (eight at Annie Brydon and three at Te Mahana) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.

Residents' files (nine at Annie Brydon and five at Te Mahana) reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights including informed consent and was last provided by the Health and Disability Advocate in October 2013 at Annie Brydon and in August 2013 at Te Mahana.

The district health board contract 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.

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

**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.

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

**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.

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

**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:**

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.

Resident meetings are held monthly at both facilities and minutes are reviewed for Te Mahana and provide evidence of discussion on the Code with residents by the independent advocate. The advocate is interviewed at Te Mahana during this audit and confirms they visit the facility at least twice a week to provide advocacy and support for residents.

Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records.

Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the Nationwide Advocate details are displayed along with advocacy information brochures. The admission pack is reviewed and provides evidence of advocacy, complaints and Code of Rights information is included.

The district health board contract 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:**

There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme at both facilities includes access to community groups and there are systems in place to ensure residents remain aware of current affairs, including reading of the newspaper each day.

Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available at each facility to take residents on community visits. Some residents go out independently on a regular basis.

Residents' files reviewed demonstrate that activity plans identify support/interest groups. Progress notes and care plan content includes regular outings and appointments (records sighted).

The district health board contract 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:**

There are appropriate systems in place to manage the complaints processes and these are reviewed during this audit. A complaints register is maintained at each facility, and there are three complaints recorded in the complaints register for 2014 and three for 2013 at Annie Brydon and two are recorded at Te Mahana for 2013 and none for 2014. Reporting of complaints occurs at the monthly quality meetings, via the monthly quality reports and monthly Te Mahana manager's report to the directors. The facility manager at Annie Brydon is one of the directors and provides this information to the other directors during their monthly directors meetings. The facility manager and quality manager at Annie Brydon report they have one complaint that is currently being investigated by the Health and Disability Commissioner and documents relating to this complaint are reviewed during this audit. The manager at Te Mahana advises there have been no complaint investigations by the Health and Disability Commissioner since the last audit. Both managers' report there has been no complaint investigations by the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are reviewed and are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents / their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly and review of these minutes provides evidence of residents' ability to raise any issues they have, and this was confirmed during interviews of residents.

A visual inspection of the facilities provides evidence that the complaint process is readily accessible and/or displayed. Review of quality and staff meeting minutes, registered nurse/enrolled nurse, staff meeting minutes and monthly manager's reports to the directors provide evidence of reporting of complaints.

The district health board contract requirements are met.

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

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

**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:**

Annie Brydon Complex Limited (ABCL) is the governing body and there is quality and risk management systems in place (see link 1.2.3.8).

A business plan for July 2013 – June 2015 and a quality improvement plan for July 2014 – June 2016 are reviewed and include a mission statement, core values, key result areas, quality objectives and scope of service. ABCL has established systems in place which defines the monitoring and reporting processes against the business plan and the risk management plan. The monitoring systems include regular monthly reporting by the Te Mahana facility manager and the quality manager to the governing body and some of these reports are reviewed. The Annie Brydon facility manager is one of the directors and also provides reports to the directors' monthly meetings. Directors meeting minutes are reviewed and provide evidence of reporting of quality improvement data.

Documented values, mission statement and philosophy are also reviewed and these are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Meeting schedules and minutes reviewed at both facilities provides evidence that monthly quality meetings are held at Annie Brydon Complex that are attended by both facility managers, the clinical nurse leader (CNL) the quality manager and the directors. Staff meetings are also held at both facilities monthly and registered nurse (RN) and enrolled nurse (EN) are also held at Annie Brydon Complex monthly. Resident meetings are held at both facilities monthly. Meeting minutes are available for review by staff along with quality reports, clinical indicator reports and graphs of clinical indicators.

The manager at Annie Brydon, who is a registered nurse, is also one of the directors and has been in this position since June 2001. The manager is supported by a newly appointed clinical nurse leader (CNL), who is an experienced registered nurse and who was appointed in December 2013. The CNL is responsible for the management of clinical care for residents. The management team also includes an experienced quality manager as well as an RN and an EN who are care co-ordinators of each of the two units at Annie Brydon. The manager from Annie Brydon also provides support for the manager at Te Mahana one day a week. Te Mahana is managed by a non-clinical manager who was appointed to this position in December 2006. The Te Mahana manager has extensive experience in the aged care sector. The directors work on site at Annie Brydon and each one has designated areas of responsibility. Organisational charts are reviewed for Annie Brydon and Te Mahana.

The managers for both facilities, the clinical nurse leader's and the two care co-ordinator's personal files and education records are reviewed and provide evidence of maintaining knowledge and current practice. The RNs and ENs have current annual practising certificates.

Annie Brydon Complex Limited is certified to provide hospital and rest home level care and on the day of this audit there are 12 hospital level residents and 55 rest home level care residents at Annie Brydon and 18 rest home residents at Te Mahana. Annie Brydon Complex Limited has contracts with the DHB to provide aged related residential care and chronic health conditions at Annie Brydon and Te Mahana and residential respite services at Annie Brydon.

The district health board contract requirements are met.

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

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

**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:**

There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager from either site be absent. The clinical nurse leader (CNL) and one of the other directors fills in for the manager at Annie Brydon and the manager from Annie Brydon fills in for the manager from Te Mahana if they are absent and both are interviewed during this audit. The manager, who is an RN, assumes responsibility for clinical management if the CNL from Annie Brydon is absent. The directors are also available for support if required.

Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the FM and CNL confirm their responsibility and authority for their roles.

The district health board contract requirements are met.

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

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

**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:** PA Low

#### **Evidence:**

A quality and risk management plan and business plan are used to guide the quality programme and include quality goals and objectives. Annie Brydon Complex and Te Mahana Rest Home have established and documented quality and risk management systems in place. Improvements are required with the development and implementation of corrective action plans to address shortfalls identified during internal audits (see criterion 1.2.3.8).

The manager/RN/director at Annie Brydon is responsible for co-ordinating the quality and risk management programme at Annie Brydon and Te Mahana. The manager/RN/director is supported by a full time quality manager who is employed to oversee the quality and risk management programmes at these two facilities as well as at another facility owned by the directors.

There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to the governing body / directors via the monthly quality meetings, which the directors attend as they work on site at Annie Brydon complex and via the monthly quality reports. Quality meeting minutes and staff meeting minutes are reviewed and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Registered nurse/enrolled nurse (RN/EN) meetings minutes are reviewed and also provide evidence of reporting of quality improvement data.

Various quality registers and documentation is reviewed at both facilities and provides evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality, staff, RN/EN meetings. Resident meetings are held monthly in each of the two units at Annie Brydon Complex as well as at Te Mahana Rest Home.

Staff interviewed report they are kept informed of quality and risk management issues including clinical indicators. Staff interviewed report this information is discussed with them at hand-over between shifts and during their meetings. This information is also reviewed in the staff newsletters. Copies of meeting minutes are available for staff to review in the staff offices and include graphs of clinical indicators.

Resident and family satisfaction surveys are completed monthly and collated results are reviewed. Different residents/family members are surveyed each month and the results are collated at the end of each month. The results are reported via the monthly quality meetings and staff meetings and the managers' reports. Feedback is also provided to residents via their monthly meetings. Any areas identified as requiring improvement during these surveys are addressed immediately. Month by month comparisons are made of the residents feedback and review of this data and individual responses indicates high levels of resident satisfaction. A 'Short term and post admission follow-up survey' of residents is also undertaken and the results for 2014 are reviewed during this audit.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service and reflects current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Policies and procedures are reviewed by the quality manager following consultation with clinical personnel. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

A health and safety manual is available that includes relevant policies and procedures and is reviewed during this audit. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed and all biomedical equipment have appropriate performance verified stickers in place and/or calibration reports.

The district health board contract requirements are met.

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

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

**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.

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

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

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

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

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

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

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

**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:** PA Low

**Evidence:**

Internal audit schedules for 2013 and 2014 are reviewed that identifies audits to be completed each month.

Internal audits that have been completed for 2013 and 2014 are reviewed and at the end of each audit tool there is space to record the audit outcomes, areas for improvement and any corrective actions required. The signature of the person completing the audit is included as is the date the audit is completed.

Quality and risk meeting minutes, registered nurse/enrolled nurse meeting minutes, resident meeting minutes and staff meeting minutes are reviewed and identify the action to be taken and the initials of the person responsible for taking the action. The person responsible for taking the action puts their initialled signature next to their initials in the 'by whom' column of the minutes when they have completed that action to be taken.

Accident/incident forms include corrective action/s taken, preventative measures, person/s notified and evidence that the action required has been taken.

**Finding:**

Corrective actions that are documented following internal audits at Annie Brydon Complex and Te Mahana Rest Home are vague and do not clearly describe the corrective action required to address any shortfalls that are identified during the internal audit. The corrective action/s do not identify the person responsible for implementing the corrective action/s, do not have a timeframe for implementing the corrective action/s and do not provide evidence the corrective action plan/s has been implemented, monitored and signed off as having been completed.

**Corrective Action:**

Provide documented evidence that (i) corrective action plans are developed, implemented, monitored and signed off as being completed that addresses all areas identified as requiring improvement in internal audits; (ii) the person/s responsible for implementing the corrective action and the timeframes for implementation are documented.

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

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

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

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an 'Accident/ Incident Form' which are reviewed by the clinical nurse leader at Annie Brydon. At Te Mahana the manager and the manager/RN/director from Annie Brydon review all accident/incident forms. Accidents/incidents are recorded on an 'Incident/Accident Analysis Form' which is a register of events and the 2013 and 2014 data is reviewed. Corrective action plans to address any areas identified as requiring improvement are documented on the 'Accident/ Incident Form' and there is evidence of monitoring of this.

Resident's files (nine at Annie Brydon and five at Te Mahana) reviewed as well as accident and incident forms, residents progress notes, and family communication sheets provide evidence that communication/contact with family is being documented following adverse events (as appropriate) involving the resident, or when there is any change in the residents condition. Family members interviewed during this audit advise they are contacted if their family member has an accident/incident, and/or if there is any change in their condition.

Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions; policies and procedures; and professional codes of conduct, which this is confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (e.g., health and safety, human resources, infection control).

The district health board contract requirements are met.

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

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

**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:**

Written policies and procedures in relation to human resources management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (nine at Annie Brydon and four at Te Mahana) along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments (as appropriate), and annual practising certificates for the registered nurses and enrolled nurses. Copies of annual practising certificates are also reviewed for staff that require them to practice.

The clinical nurse leader (CNL) at Annie Brydon and the manager at Te Mahana are responsible for management of the in-service education programme at each facility and there is evidence available indicating in-service education is provided for staff at least once a month. The education planners for 2013 and 2014 are reviewed and provide evidence that ongoing education is provided. A competency register is maintained and the registers for 2013 and 2014 are reviewed during this audit and indicate staff have current competencies in place as appropriate.

Staff are supported to complete the Aged Care Education (ACE) modules and one of the directors provides weekly sessions to assist staff with completion of the ACE modules. Individual records of education are maintained for each staff member and copies are reviewed on an electronic database (Annie Brydon) as well as paper based records. Current staff appraisals are sighted on all staff files reviewed.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The manager at Te Mahana and the CNL at Annie Brydon advise that staff are orientated for at least three shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of

the service provided and includes but is not limited to: the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy.

Care staff interviewed (six at Annie Brydon and four at Te Mahana) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale (Staffing Rationale Policy) for determining service provider levels and skill mixes in order to provide safe service delivery (see link criterion 1.3.4.2). Twenty four hour registered nurse cover is provided at Annie Brydon Complex. The minimum amount of staff is provided during the night shift and currently consists of one registered nurse and two caregivers at Annie Brydon Complex and one care giver at Te Mahana. The clinical nurse leader is available after hours for clinical issues, and the facility manager for business/administration issues if required at Annie Brydon. The manager/RN from Annie Brydon and the manager from Te Mahana are also available after hours if required.

The service provider uses a 'Models of Care' tool that allocates a set number of care staff hours per resident in the rest home and in the hospital that is based on best practice and indicates the variance per hour on a day by day basis. This is reviewed during this audit.

All care staff interviewed at both facilities report there is adequate staff available and that they are able to get through their work. Care staff report they work well as a team to provide assistance to each other. Residents and family interviewed report there is enough staff on duty to provide them with adequate care.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident information is entered in an accurate and timely manner into a paper based register at each facility that is in line with legislative requirements. Interview with the managers at both facilities confirms the resident details are entered into the register on the day of admission. The quality manager advises they are proposing to introduce an electronic register.

Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the resident's clinical record is made on each shift and entries are clear, dated and signed.

A visual inspection of the facilities provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier.

Clinical staff interviewed (three RNs, one EN and five care givers); the clinical nurse leader and the facility managers confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.

The district health board contract 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:**

The documented systems and processes are implemented to ensure residents' entry into the services are facilitated in a competent, equitable, timely and respectful manner. Policies and procedures for entry criteria, assessment and entry screening are recorded and implemented. The philosophy is recorded, displayed at both facilities and communicated to residents, family, relevant agencies and staff.

The admission agreement defines the service scope and includes all the contractual requirements, sighted. All residents' (nine of nine residents' files at Annie Brydon Complex and five of five residents' files at Te Mahana Rest Home) admission agreements record residents' and facility representatives' sign off. Two of two managers interviewed (one manager at the Annie Brydon Complex and one manager at the Te Mahana Rest Home) confirm access and entry processes at both facilities are followed. Both facilities operate 24/7.

Resident information booklets and welcome packs were sighted and contain all relevant information for the resident and family. Residents' files (nine of nine resident files at Annie Brydon Complex and four of five residents' files at Te Mahana Rest Home ) sampled demonstrate all needs assessments are completed for appropriate levels of care (refer to criterion 1.3.4.2).

Eight of eight residents (six rest home and two hospital) interviews and eight of eight family (three rest home and five hospital) interviews at Annie Brydon Complex confirm their input into the admission process. Four of four residents and three of three family at Te Mahana Rest Home confirm appropriate information is provided about the home and satisfaction with communication with the manager and staff.

The district health board 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:**

The scope of the services provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the managers at the Annie Brydon Complex and the Te Mahana Rest Home. The resident will be declined entry if not within the scope of the service or if a bed is not available at the time. The managers state the resident will be referred back to the NASC service.

**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:**

In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with the resident and/or the family input and the services are coordinated to promote continuity of service delivery at both facilities.

Six of six clinical staff interviews (one clinical team co-ordinator (enrolled nurse, EN), one registered nurse, RN, one clinical nurse leader (RN) and three care givers) at the Annie Brydon Complex and four of four clinical staff interviews (two care givers and two RNs) at the Te Mahana Rest Home confirm the residents and/or the family members are involved in all stages of the service provision.

Eight of eight residents (six rest home and two hospital) interviews and eight of eight family (three rest home and five hospital) interviews at the Annie Brydon Complex and four of four residents and three of three family at the Te Mahana Rest Home confirm their input into assessments, service delivery planning, care evaluations and multidisciplinary reviews.

Nine of nine residents' files (five rest home and four hospital) at Annie Brydon Complex and five of five residents' files at the Te Mahana Rest Home demonstrate the long term care plans are developed by the RNs, signed off by the resident and/or the family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. The family communication sheets are maintained, sighted in all of the residents' files reviewed at both services.

Documented handovers between shifts are sighted and the auditor evidenced verbal briefing from am to pm shift at the Annie Brydon Complex.

Two of two GP interviews are conducted (one GP for the Annie Brydon Complex and one GP for the Te Mahana Rest Home). The GPs confirm that staff inform the GPs of any resident medical issues and concerns in timely manner and GPs prescribed treatments are followed by staff.

The staff competency assessments are current and the staff competency register records competencies for all clinical staff in restraint, staff who administer medicines have current medication competencies and insulin administration, nebuliser and oxygen competencies. RNs also complete wound competencies and all clinical staff are educated in and complete hoist competencies.

The service delivery audit was conducted in February 2014 at the Annie Brydon Complex and evidences there are corrective actions to be taken to address the shortfalls (refer to criterion 1.2.3.8).

Three tracer methodologies are conducted: one rest home and one hospital resident at Annie Brydon Complex and one rest home resident at the Te Mahana Rest Home.

The district health board contract requirements are met.

Tracer methodology-hospital –Annie Brydon Complex:

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

Tracer methodology-rest home-Annie Brydon Complex

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

Tracer methodology-rest home-Te Mahana rest home.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. The residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider are located in the clinical files, where required.

The NASC assessments are available for appropriate levels of care, sighted in the five of five rest home files and the four of four hospital files at Annie Brydon Complex and four of five residents' files at the Te Mahana Rest Home and this requires an improvement.

The facilities have appropriate resources and equipment. The clinical nurse leader (RN) interview at Annie Brydon Complex and the manager interview at the Te Mahana Rest Home confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Eight of eight residents (six rest home and two hospital) and eight of eight family (three rest home and five hospital) interviews at Annie Brydon Complex and four of four residents and three of three family interviews at the Te Mahana Rest Home confirm their involvement in assessments, care planning, review, treatment and evaluations of care.

Nine of nine residents' files (five rest home and four hospital) at Annie Brydon Complex and five of five residents' files at the Te Mahana Rest Home evidence risk assessments are conducted on admission and recorded on the residents' care plans. The residents' initial care plans are recorded on admission and the long term care plans are recorded within the required timeframe and evaluated at six monthly intervals or when the resident's condition alters.

There are areas requiring improvement around residents' assessments to be conducted as per the DHB contract at the Annie Brydon Complex and a NASC reassessment to be completed for a resident with high level of care at the Te Mahana Rest Home.

The district health board contract requirements are not fully 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:** PA Low

**Evidence:**

The assessments of residents do not always provide evidence they have been undertaken by a registered nurse. The registered nurse's signature is not always recorded on the residents' records that have been assessed and reviewed by an enrolled nurse at Annie Brydon Complex. One resident requiring a high level of care at the Te Mahana Rest Home requires a current NASC assessment.

**Finding:**

The residents' clinical files reviewed at the Annie Brydon Complex evidence the residents' assessments are conducted by an enrolled nurse and not signed off by the RN. A resident requiring a high level of care at the Te Mahana Rest Home requires a current NASC assessment.

**Corrective Action:**

- i) Provide evidence the residents' assessments are conducted as per the DHB contract (D 16.2b and D 17.3e) at the Annie Brydon Complex.
- ii) Provide evidence of a NASC reassessment for a resident requiring a high level of care at the Te Mahana Rest Home.

**Timeframe (days):** 180 (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:**

Nine of nine residents' files (five rest home and four hospital) at Annie Brydon Complex and five of five residents' files at the Te Mahana Rest Home evidence residents' care plans are individualised and up-to-date. The long-term and short-term goals are identified by the residents and service providers and reviewed at regular intervals, at least six monthly or as the residents' needs change. The residents have input into their care planning and review, confirmed at all resident interviews.

The clinical staff interviewed at the Annie Brydon Complex and the Te Mahana Rest Home confirm that the residents' care plans are accurate and up to date.

All residents' files sampled at both services evidence the clinical care/treatment/support or the interventions to be provided by the staff are current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members.

The facilities ensure access to regular GP care, confirmed at GP interviews.

The district health board contract 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:**

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

The nine of nine residents' files at the Annie Brydon Complex and the five of five residents' files at the Te Mahana Rest Home evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled.

GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement.

All residents interviewed confirm their current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all residents' files sampled.

The district health board contract 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:**

The residents' activities assessments are completed on admission. The residents' activities care plans record the residents' support needs in the areas of creativity, intellectual abilities, individual preferences, outings, physical needs, social needs, spiritual needs and cultural needs. The activities care plan is reviewed six monthly, sighted current reviews in all care plans reviewed. The activities care plan reviews have input from the multidisciplinary team and the resident or their family.

There are two recreational officers employed at the Annie Brydon Complex. Interviews with the two recreational officers at the Annie Brydon Complex confirm the activities programme meets the needs of the service group and the service has appropriate equipment. The monthly activities programmes at Annie Brydon Complex is sighted. Recreational officers state the residents receive monthly programme and the daily activities are written on white boards at the facility, sighted.

The Te Mahana Rest Home monthly activities programme is sighted and interview with the activities officer is conducted. There is evidence of community involvement in the activities provided at the Te Mahana Rest Home on audit day.

Residents, family and staff interviews at both facilities confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.

Residents' meeting minutes evidence residents' discussion in relation to the activities programme - sighted minutes from meetings in 2014 in both the Annie Brydon Complex and Te Mahana Rest Home. Te Mahana Rest Home residents' meetings are chaired by an independent advocate. Interview with the advocate confirms monthly residents meetings are conducted.

A recreational programme audit was conducted in January 2014 and June 2014 at the Annie Brydon Complex with corrective actions to be addressed (refer to criterion 1.2.3.8).

Residents interviewed at both facilities confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and were sighted at both facilities.

The district health board contract 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:**

All residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Evaluation are conducted by the RNs with input from the resident, family, care staff, recreational officers and GPs. The family are notified of any changes in the resident's condition, evidenced in all the residents' files sampled and confirmed at the family interviews.

The residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. The residents' files evidence referral letters to specialists and other health professional. The multidisciplinary reviews are current.

The district health board contract 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:**

The service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. The residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. district nursing service, DHB specialists. The residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

The district health board contract 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:**

The residents files sampled evidence appropriate communications between the family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files.

The district health board contract requirement is 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 visual inspection of the medication areas at the Annie Brydon Complex, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. There are two controlled drug storages at the Annie Brydon Complex (one at the Annie Brydon wing and one at the Brydon Court wing) and they are secure. The medication area at the Te Mahana Rest Home is secure.

The controlled drug registers at the Annie Brydon Complex and the Te Mahana Rest Home are maintained, evidence weekly checks and the six monthly physical stock takes of controlled drugs are also noted on the registers. Medication rounds are observed at the Annie Brydon Complex and at the Te Mahana Rest Home and evidence staff are signing off as the dose is administered. Medication fridge temperatures are monitored.

Sighted medication audit results from March 2014 at the Annie Brydon Complex, with corrective action to be addressed (refer to criterion 1.2.3.8).

All staff authorised to administer medicines at both facilities have current competencies, sighted in staff files sampled and on the staff competency registers. Training and education relating to medication management systems are conducted and current at both facilities.

Twenty medicine charts (10 rest home and 10 hospital) are sampled at Annie Brydon Complex and 10 medicine charts sampled at the Te Mahana Rest Home. All medication charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. All residents' medicines charts sampled list all medications a resident is taking (including name, dose, frequency and route to be given). The residents' standing orders are current and authorised by GPs.

There are no residents that self-administer medicines at the Te Mahana Rest Home. There are residents at the Annie Brydon Complex who self-administers medicines and there is evidence of the residents' competency assessments, residents' signing sheets and the medicines are safely stored. Interview with one resident who self-administers medicines was conducted and evidences the resident is competent and aware of the responsibilities with self-administration of medicines.

The district health board contract 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:**

Food services policies and procedures are appropriate to the service setting with a new seasonal four weekly menu being introduced six monthly, confirmed at kitchen staff interviews. The menu is being reviewed by a dietitian, sighted correspondence in respect of the menu review.

The resident's individual dietary needs are identified, documented and reviewed on a regular basis as part of the care plan review. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with kitchen staff/ cooks at both facilities. Copies of current residents' dietary profiles are reviewed in the kitchens at the Annie Brydon Complex and the Te Mahana Rest Home and in residents' files.

The residents' files sampled demonstrate monthly monitoring of individual resident's weight. The residents interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. The food temperatures are recorded, sighted. The fridge and freezer temperatures are recorded, sighted. The decanted foods are dated. The kitchen staff have current food safety training.

The food services audit was conducted in February 2014 at Annie Brydon Complex with corrective actions to be addressed (refer to criterion 1.2.3.8).

The district health board contract 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:**

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout both facilities and are accessible for staff. Hazard registers are available at each site and are current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in July and September 2013 at Annie Brydon and Te Mahana respectively. Monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes.

Sluice facilities are available for the disposal of waste and hazardous substances. A visual inspection of the facilities provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in the sluice rooms, laundry and cleaners' room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.

The district health board contract requirements are met.

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

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

**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:**

There have been no alterations undertaken at either Annie Brydon or Te Mahana since the last audit. Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

Maintenance is contracted out at Te Mahana and a maintenance person is employed for 10 hours a week at Annie Brydon and is interviewed during this audit. During interview the maintenance person confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit. Current calibration / performance reports for medical equipment, electrical testing and tagging reports are reviewed at both facilities. A current Building Warrant of Fitness is displayed at Annie Brydon Complex that expires 15 October 2014 and at Te Mahana that expires 26 August 2014.

A visual Inspection of both facilities provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to a high standard. Corridors are wide enough to allow residents to pass each other safely in both facilities. Safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order. The external areas

are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (for example, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).

Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (for example hoists competency). This was confirmed during interview of staff and review of staff education records. Care staff interviewed confirm they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.

Residents interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

The district health board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**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:**

All bedrooms at both Annie Brydon and Te Mahana have wash hand basins and several at Annie Brydon have full ensuite facilities. There are an adequate number of toilet and shower facilities available throughout the facility.

Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and wash basin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.

**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.

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

**Standard 1.4.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Visual inspection provides evidence that with the exception of two bedrooms in the hospital area at Annie Brydon, all bedrooms provide single accommodation. The bedrooms at Annie Brydon are large and adequate personal space is provided to allow residents and staff to move around within the room safely. The bedrooms at Te Mahana are smaller but are still large enough to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Resident's bedrooms are personalised to varying degrees.

**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.

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

**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:**

Visual inspection at Annie Brydon Complex and at Te Mahana provides evidence that adequate access is provided to multiple lounges, dining rooms, activities lounges and conservatory. Residents are observed moving freely within these areas. There are multiple areas for sitting throughout Annie Brydon and the 24 care suites at Annie Brydon have lounges. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

#### **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:**

Cleaning policy and procedures and laundry policy and procedures are available at both facilities. There are policies and procedures for the safe storage and use of chemicals/poisons.

There are two laundries at Annie Brydon (one in each unit) and one at Te Mahana. All linen is washed on site at each facility and there is adequate dirty / clean flow. A laundry worker is interviewed at Annie Brydon and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents. Care staff are responsible for management of the laundry at Te Mahana and are able to describe the management of laundry during interview.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed at both facilities. A cleaner is interviewed at both Annie Brydon and Te Mahana and they describe the management of cleaning processes including the use of personal protective equipment.

Visual inspection of both facilities provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Residents interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of completed family and resident satisfaction surveys.

The district health board contract requirements are met.

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

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

**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:**

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

A New Zealand Fire Service (NZFS) letter dated 17 July 2013 for Annie Brydon is reviewed advising the evacuation scheme was approved on 19 July 1998. A New Zealand Fire Service (NZFS) letter dated 31 July 2009 for Te Mahana is reviewed advising the evacuation scheme is approved. A trial evacuation was held at Annie Brydon on 02 April 2014 and on 12 May 2014 at Te Mahana. Fire safety education was provided at both facilities as part of the trial evacuation.

Registered nurses, enrolled nurses and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training. All staff at Te Mahana have current first aid certificates.

Staff interviews and review of staff files provides evidence of current training in relevant areas. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff confirm recent education on fire, emergency and security situations. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Emergency management training was last provided in July 2014.

Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facilities provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.

There is a call bell system in place at both facilities that are used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff respond to it in a timely manner. This is also confirmed during review of completed resident satisfaction surveys.

The district health board contract requirements are met.

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

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

**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.

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

**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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents interviewed confirm the facilities are maintained at an appropriate temperature.</p> <p>The district health board contract requirements are met.</p>
---

**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.

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

---

### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The services at the Annie Brydon Complex and the Te Mahana Rest Home have an overarching risk and quality management systems that demonstrate compliance with the restraint minimisation and safe practice (RMSP) standard. The definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is recorded. Documented systems are in place to ensure the use of restraint is actively minimized.

There are 12 residents utilising restraint and three residents utilising enablers at the Annie Brydon Complex. There is one resident utilising restraint and no enabler use at the Te Mahana Rest Home. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Staff education programme includes RMSP /enabler training and this was conducted in 2014 in both facilities. Staff competency registers record restraint competencies for all clinical staff are current.

The restraint and enabler policy compliance audit was conducted in April 2014 with 100% compliance. The challenging behaviour audit was conducted in January with 100% compliance.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The services have systems in place for determining the restraint approval processes. The staff interviewed and the residents' files sampled evidence responsibilities are identified and known. Residents' files sampled evidence residents and /or family input into the restraint approval processes. Restraint meetings evidence an approval review process.

There is a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The restraint coordinators positions at both facilities are delegated to suitably skilled and experienced service providers. Interviews with the restraint co-ordinators is conducted.

The clinical staff interviewed are aware of the restraint co-ordinators' responsibilities. RMSP policy/procedures define approved restraints and alternatives to restraint. There are policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement. The orientation/induction programme includes overview of RMSP policies/procedures. Staff education programme includes on-going RMSP training, conducted in May and June 2014.

The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Systems are in place to ensure assessment of the resident is undertaken prior to restraint usage being implemented. The residents' files sampled demonstrate restraint assessment and risk processes are being followed. Policies relate to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.

Residents' files sampled evidence restraint assessment risks are documented and evaluated on a regular basis and include resident and/or family input. Multidisciplinary reviews evidence restraint assessment risks are reviewed.

The district health board contract requirement is met.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

Appropriate systems are in place to ensure the services at both facilities are using restraint safely. The restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The residents' files sampled evidence evaluations / review of restraint goals / interventions. The restraint review forms evidence current reviews.

The residents' files sampled demonstrate appropriate alternative interventions are implemented and de-escalation attempted prior to initiating restraint. The restraint consent by resident and/or family are current. The residents' files sampled demonstrate the details of the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint, any advocacy/support offered, provided, or facilitated. Service provider's documentation evidences a restraint register is established that records sufficient information to provide an auditable record of restraint use. On the days of the audit there were 12 residents utilising restraint and three residents utilising enablers at the Annie Brydon Complex. There was one resident utilising restraint and no enabler use at the Te Mahana Rest Home.

The district health board contract requirement is met.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used.

The evaluation of restraint usage is sighted for 2014. The residents' files sampled demonstrate residents' care plan evaluations and multidisciplinary meetings are current.

The district health board contract requirement is met.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint reviews occur on a regular basis and cover all the necessary components. The restraint audits completed in April 2014 are reviewed for Annie Brydon and Te Mahana and the outcomes of these reviews are documented and reported on, as well as being discussed at meetings. The RMSP policies and procedures include monitoring and quality review processes.

The district health board contract requirement is met.

**Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)**

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

(a) The extent of restraint use and any trends;

- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

---

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection prevention and control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control. Clinical staff interviewed confirm the infection control management systems provide them with adequate guidance.

The delegation of infection control matters throughout the organization is documented along with an IC officers' job description. There is documented evidence of infection related issues by regular reporting systems.

Visual inspections of both facilities evidence staff provide additional infection management precautions. The IC programme was last reviewed in 2014.

The district health board contract requirement is met.

**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 infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC co-ordinators / RNs at both facilities are qualified health professionals with relevant skills, expertise and resources necessary to achieve the requirements of this standard. The IC co-ordinators report access to DHB/microbiologist/GP & other health care professionals, as required.

The IC co-ordinators have access to relevant and current information which is appropriate to the size and complexity of the organization, including: IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education.

The district health board contract requirement is met.

### 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:**

Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel. IC policies and procedures identify links to other documentation in the organisation e.g. health & safety, quality and risk. Clinical staff interviewed confirm infection control policies and procedures are freely available for them.

The district health board contract requirements are met.

#### **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:**

IC is part of the on-going in-service education programme. The IC co-ordinators' education/ training in IC matters is current.

The IC co-ordinators and other staff interviewed advice that clinical staff identify situations where IC education is required for a resident such as; hand hygiene, cough etiquette, multi-resistant micro-organisms and this is conducted.

Staff education on IC was provided in February 2013 by DHB staff and in March 2014 by the IC co-ordinator at Annie Brydon Complex and in June 2014 at the Te Mahana rest home. All education sessions have evidence of staff attendance and content of the presentations.

The district health board contract requirement is met.

#### 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:**

The IC programme/policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes.

Infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. Infection logs are maintained. Numbers of infections are collated at the end of each month and reported as a clinical indicator to staff and quality meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers.

#### **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.)*