# Opunake Districts Rest Home Trust

## Current Status: 28 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

The Cottage Rest Home provides residential care for up to 22 rest home residents and occupancy was 22 during this audit. The governing body is the Opunake Districts Rest Home Trust which is a community trust made up of six trustees from the local community.

Seven areas were identified as requiring improvement during this audit. The improvements relate to: the comprehensiveness of the policies and procedures; documentation of corrective action plans to address areas identified as requiring improvement; completion of medication competencies by staff; staff use of appropriate personal clothing when handling soiled linen; consent documentation; management of self-administration of medicines by residents and management of medication documentation.

Residents and family interviewed provided positive feedback on the care and service provided at The Cottage Rest Home.

## Audit Summary as at 28 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 28 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 28 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 28 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 medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 28 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Restraint Minimisation and Safe Practice as at 28 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 28 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 28 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, was accessible and is brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirmed that 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 confirmed that consent forms are provided to them prior to admission to ensure they have time for consultation and they are fully informed. Improvements are required with the management of consent documentation including permission from the resident to take and use their photograph on the resident’s clinical documentation. Advocates are available for residents and visits on a weekly basis.

The manager is responsible for the management of complaints and a complaints register was maintained. The residents can use the complaints forms or raise issues at the residents' meetings.

### Organisational Management

Opunake Districts Rest Home Trust (ODRHT) is the governing body and is responsible for the service provided at The Cottage Rest Home (The Cottage). Key planning documents are reviewed and include a strategic plan with a SWOT analysis (strengths, weaknesses, opportunities and threats) for various aspects of the service. Also reviewed are a philosophy, mission statement and business summary. Systems are in place for monitoring the service provided at The Cottage, including reporting by the manager to the monthly ODRHT monthly meetings.

The Cottage is managed by a suitably qualified and experienced registered nurse who maintains their knowledge and current practice who was appointed to this position in February 2010. The manager worked in a rehabilitation unit at a District Health Board (DHB) prior to this appointment. The manager is supported by a registered nurse who works 20 hours a week. Both registered nurses (RN's) have current annual practising certificates and have undertaken training in relevant areas.

Improvements are noted with the management of the quality and risk management systems since the last audit, however, improvements are still required to two aspects of these systems. The improvements required relate to the comprehensiveness of the policies and procedures that were implemented following the last audit and management of corrective action plans to address areas identified as requiring improvement. 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 governing body. There is an internal audit programme in place. 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 health professionals who require them. There is evidence available indicating an in-service education programme is provided for staff at least monthly and education records are maintained. Improvements are required with the completion of medication competencies as although care staff have completed medication questionnaires their practical competency has not been assessed. Staff records reviewed provides evidence that human resources processes are followed and include but is not limited to reference checking, criminal history vetting and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The manager/registered nurse is also on-call after hours. Care staff report they work well as a team to provide assistance to each other.

Resident information was entered into a register 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

Entry criteria, assessment and the entry screening processes are documented, communicated to residents and where referral and entry to the service is declined the immediate risks for residents are managed. Assessments are conducted in a timely manner and risk assessment findings are recorded on the residents' long term care plans. Initial care plans are completed on admission. Long term care plans are resident focussed and promote continuity of care. The long term care plans describe the required support and interventions in order to achieve the identified goals.

Documentation and observations of service delivery demonstrate that consultation and liaison is occurring with other services. Family demonstrates participation in the long term care planning process by signing the care plan. Care plan evaluations are conducted by the registered nurses with input from the GP. Residents are given opportunities to choose their own general practitioner and where they will access other health and disability services. The service providers identify, document and minimise risks associated with each resident’s transition, exit, discharge and or transfer.

The activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations. Rest home residents' meeting minutes evidence residents' discussion in relation to the activities programme.

Inspection of the medication management area evidences an appropriate and secure system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes of controlled drugs by Pharmacist are noted. The general practitioner signs and dates all entries, allergies are recorded, each medicines chart has photo identification and the general practitioner signs, dates and crosses out discontinued medicines, however there are requirements for improvement relating to staff having to be observed completing a medicines round to demonstrate competency, the general practitioner having to sign and date the medicines charts at the time of review and self-administration of medicines to be safe and appropriate.

Food services policies and procedures are appropriate to the service setting. There is a seasonal four weekly menu being used. Dietary assessment records are used in the kitchen to ensure food services are familiar with the dietary needs of residents and kept in residents' files. Additional snacks are available for residents when the kitchen is closed.

### Safe and Appropriate Environment

With the exception of one double bedroom that is used by a couple, all bedrooms provide single accommodation. All bedrooms have wash hand basins and there are three bedrooms with full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. Building alterations have been undertaken in one area of the building to improve access to the external garden area at the back of the building. Other external areas are also available for sitting and shade is provided. Appropriate call bell systems are available and security systems are in place.

Review of documentation provided evidence there are appropriate systems in place to ensure the residents’ physical environment is safe and that the facilities are fit for their purpose.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. All laundry is washed on site and the cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. However, improvements are required with the personal protective clothing worn by staff when handling soiled linen.

Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided.

### Restraint Minimisation and Safe Practice

The service implements a process for approving restraints including the duration of the restraint and on-going education and training, sighted training records. The responsibility of the restraint coordinator is clearly defined and there are clear lines of accountability attached to the role.

The service implements assessment processes to ensure the safe and appropriate management of restraints. Restraint assessments include the requirements of the Standard. In assessing whether restraint will be used, appropriate factors are taken into consideration. Restraints are used as the last resort. The service maintains a restraint register. Restraints are monitored and evaluated. Restraints are recorded in the long term care plans.

### Infection Prevention and Control

The responsibility for infection control is clearly defined in a job description and the infection control programme is reviewed annually. The service has the resources to implement the infection control programme.

Infection control is the responsibility of all the staff. Infections are reported on and discussed at monthly staff meetings. The infection control coordinator attends training and is responsible for training and education for staff. The surveillance data is collected, collated and analysed to identify areas for improvement.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Opunake Districts Rest Home Trust |
| **Certificate name:** | Opunake Districts Rest Home Trust |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Opunake Districts (The Cottage) Rest Home |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 28 July 2014 | **End date:** | 29 July 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 22 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 12 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 23.5 | Total audit hours | 47.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 12 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 24 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, 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 Monday, 4 August 2014

## **Executive Summary of Audit**

**General Overview**

The Cottage Rest Home provides residential care for up to 22 rest home residents and occupancy was 22 during this audit. The governing body is the Opunake Districts Rest Home Trust which is a community trust made up of six trustees from the local community.

Seven areas were identified as requiring improvement during this audit. The improvements relate to: the comprehensiveness of the policies and procedures; documentation of corrective action plans to address areas identified as requiring improvement; completion of medication competencies by staff; staff use of appropriate personal clothing when handling soiled linen; consent documentation; management of self-administration of medicines by residents and management of medication documentation.

Residents and family interviewed provided positive feedback on the care and service provided at The Cottage Rest Home.

**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, was accessible and is brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirmed that 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 confirmed that consent forms are provided to them prior to admission to ensure they have time for consultation and they are fully informed. Improvements are required with the management of consent documentation including permission from the resident to take and use their photograph on the resident’s clinical documentation. Advocates are available for residents and visits on a weekly basis.

The manager is responsible for the management of complaints and a complaints register was maintained. The residents can use the complaints forms or raise issues at the residents' meetings.

**Outcome 1.2: Organisational Management**

Opunake Districts Rest Home Trust (ODRHT) is the governing body and is responsible for the service provided at The Cottage Rest Home (The Cottage). Key planning documents are reviewed and include a strategic plan with a SWOT analysis (strengths, weaknesses, opportunities and threats) for various aspects of the service. Also reviewed are a philosophy, mission statement and business summary. Systems are in place for monitoring the service provided at The Cottage, including reporting by the manager to the monthly ODRHT monthly meetings.

The Cottage is managed by a suitably qualified and experienced registered nurse who maintains their knowledge and current practice who was appointed to this position in February 2010. The manager worked in a rehabilitation unit at a District Health Board (DHB) prior to this appointment. The manager is supported by a registered nurse who works 20 hours a week. Both registered nurses (RN's) have current annual practising certificates and have undertaken training in relevant areas.

Improvements are noted with the management of the quality and risk management systems since the last audit, however, improvements are still required to two aspects of these systems. The improvements required relate to the comprehensiveness of the policies and procedures that were implemented following the last audit and management of corrective action plans to address areas identified as requiring improvement. 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 governing body. There is an internal audit programme in place. 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 health professionals who require them. There is evidence available indicating an in-service education programme is provided for staff at least monthly and education records are maintained. Improvements are required with the completion of medication competencies as although care staff have completed medication questionnaires their practical competency has not been assessed. Staff records reviewed provides evidence that human resources processes are followed and include but is not limited to reference checking, criminal history vetting and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The manager/registered nurse is also on-call after hours. Care staff report they work well as a team to provide assistance to each other.

Resident information was entered into a register 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**

Entry criteria, assessment and the entry screening processes are documented, communicated to residents and where referral and entry to the service is declined the immediate risks for residents are managed. Assessments are conducted in a timely manner and risk assessment findings are recorded on the residents' long term care plans. Initial care plans are completed on admission. Long term care plans are resident focussed and promote continuity of care. The long term care plans describe the required support and interventions in order to achieve the identified goals.

Documentation and observations of service delivery demonstrate that consultation and liaison is occurring with other services. Family demonstrates participation in the long term care planning process by signing the care plan. Care plan evaluations are conducted by the registered nurses with input from the GP. Residents are given opportunities to choose their own general practitioner and where they will access other health and disability services. The service providers identify, document and minimise risks associated with each resident’s transition, exit, discharge and or transfer.

The activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations. Rest home residents' meeting minutes evidence residents' discussion in relation to the activities programme.

Inspection of the medication management area evidences an appropriate and secure system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks and six monthly physical stock takes of controlled drugs by Pharmacist are noted. The general practitioner signs and dates all entries, allergies are recorded, each medicines chart has photo identification and the general practitioner signs, dates and crosses out discontinued medicines, however there are requirements for improvement relating to staff having to be observed completing a medicines round to demonstrate competency, the general practitioner having to sign and date the medicines charts at the time of review and self-administration of medicines to be safe and appropriate.

Food services policies and procedures are appropriate to the service setting. There is a seasonal four weekly menu being used. Dietary assessment records are used in the kitchen to ensure food services are familiar with the dietary needs of residents and kept in residents' files. Additional snacks are available for residents when the kitchen is closed.

**Outcome 1.4: Safe and Appropriate Environment**

With the exception of one double bedroom that is used by a couple, all bedrooms provide single accommodation. All bedrooms have wash hand basins and there are three bedrooms with full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. Building alterations have been undertaken in one area of the building to improve access to the external garden area at the back of the building. Other external areas are also available for sitting and shade is provided. Appropriate call bell systems are available and security systems are in place.

Review of documentation provided evidence there are appropriate systems in place to ensure the residents’ physical environment is safe and that the facilities are fit for their purpose.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. All laundry is washed on site and the cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services. Staff have received training to ensure safe and appropriate handling of waste and hazardous substances. However, improvements are required with the personal protective clothing worn by staff when handling soiled linen.

Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided.

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

The service implements a process for approving restraints including the duration of the restraint and on-going education and training, sighted training records. The responsibility of the restraint coordinator is clearly defined and there are clear lines of accountability attached to the role.

The service implements assessment processes to ensure the safe and appropriate management of restraints. Restraint assessments include the requirements of the Standard. In assessing whether restraint will be used, appropriate factors are taken into consideration. Restraints are used as the last resort. The service maintains a restraint register. Restraints are monitored and evaluated. Restraints are recorded in the long term care plans.

**Outcome 3: Infection Prevention and Control**

The responsibility for infection control is clearly defined in a job description and the infection control programme is reviewed annually. The service has the resources to implement the infection control programme.

Infection control is the responsibility of all the staff. Infections are reported on and discussed at monthly staff meetings. The infection control coordinator attends training and is responsible for training and education for staff. The surveillance data is collected, collated and analysed to identify areas for improvement.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 3 | 4 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.4 | The service is able to demonstrate that written consent is obtained where required. | PA Low | i) General consent forms do not include consent for having the resident’s photograph taken. ii) The advance directives include the decision to resuscitate or not however one of the files reviewed has the ‘not for resuscitation’ decision signed by the enduring power of attorney (EPOA) rather than the resident. | i) The service to obtain consents for taking photographs of residents.ii) The ‘not for resuscitation’ decision to only be signed by a resident who is competent. | 180 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.3 | 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. | PA Low | Most of the policies and procedures reviewed are not comprehensive, are brief and do not provide sufficient detail to guide staff. The policies and procedures do not consistently reflect current accepted good practice and do not consistently reference legislative requirements | Provide evidence that: (i) the policies and procedures have been reviewed and adequate detail is included to provide guidance for staff; and (ii) the policies and procedures reflect current accepted good practice and reference legislative guidelines.  | 180 |
| 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 | Finding:(i)Corrective action plans following internal audits and in meeting minutes are not consistently being documented, implemented, monitored and signed off as being completed to address any shortfalls identified. (ii) Timeframes for implementation of the corrective action plans are not being consistently documented. | Provide documented evidence that: (i) corrective action plans are developed, implemented, monitored and signed off as completed to address any issues that have been identified as requiring improvement; and (ii) that timeframes are being recorded and monitored. | 180 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Staff involved in medicine management do not have current competency assessments. | Provide evidence that all staff involved in medicine management have their competency assessed and that this competency assessment is completed on a regular basis. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | The resident who self-administers medicines has not been assessed for competency, is not monitored and does not have a lockable draw for safe storage of the medicines. | The service to assess, monitor and provide residents who self-administers medicines with safe and appropriate storage for the medicines. | 30 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | There is no evidence of the GP signing and dating the medicines charts at the time of review. | Medicines charts to be signed and dates at time of three monthly review. | 30 |
| HDS(C)S.2008 | Standard 1.4.1: Management Of Waste And Hazardous Substances  | Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Staff are observed not using appropriate personal protective clothing when handling soiled linen.  | Provide evidence that staff are using appropriate protective clothing when handling soiled linen. | 60 |

## **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) and this was last provided in December 2013 by the Health and Disability Advocate. Care staff are observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents’ rights.

Residents (four) and family members (three) are able to verify that services are provided with dignity and respect, privacy is maintained, and individual needs and rights are upheld.

Interviews with staff (manager/registered nurse, registered nurse, four care givers and one activities co-ordinator) demonstrate an understanding of resident rights.

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 (the Code) and information on the advocacy service are displayed and are available at the facility and in the information pack provided on admission to the facility. The manager/registered nurse advises there is an independent advocate who visits the facility weekly. Residents interviewed confirm they have access to an independent advocate if needed.

Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility’s admission package prior to the resident’s admission. This information is reviewed and includes an ‘Opunake Cottage Rest Home Information Booklet’ and copies of this are available in resident’s bedrooms. 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 five admission agreements are reviewed and all are found to contain this level of information.

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 (four) and family members (three rest home).

Documentation reviewed provides confirmation that staff last received training on the Code in December 2013 and that this education was provided by the Health and Disability Advocate. There is also documented evidence that abuse and neglect education was last provided in March 2013.

Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents. There is one double bedrooms that the manager/ registered nurse advise are only used by couples. Curtains are used to provide privacy when bedrooms are shared.

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 (five rest home).

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 guidelines for the provision of culturally safe services for Māori residents that includes objectives, information on cultural awareness, cultural safety, Māori perspective of health, importance of whanau and use of Māori health care plans. The organisation also acknowledges Tikanga Māori in their strategic plan.

There are currently four residents in the facility that identify as Māori and the manager/registered nurse and the registered nurse describe the processes they follow when a resident who identifies as Māori is admitted. The file of one resident who identifies as Māori is reviewed during this audit and provides evidence that whanau are actively involved in the care of this resident. The manager and the registered nurse advise that family members are involved in the care of all residents at The Cottage Rest Home (The Cottage).

Access to Māori support and advocacy services is available via family members of residents and from Kuia and Kaumatua from the local iwi. A list of contacts is maintained and is reviewed.

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 residents who identify as Māori have access to appropriate services. Cultural safety education was last provided in August 2012 and is next scheduled for August 2014.

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. The manager/registered nurse describes processes on how to access appropriate expertise from for example cultural specialists and interpreters. Documentation is reviewed that confirms these processes.

Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. Cultural assessments are completed as part of the care planning process for residents.

Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. 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 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 house rules which include information on conflicts of interest including 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 six of six staff files.

A review of the accident/incident reporting system, complaints register and interviews of the manager / registered nurse 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 the facility. During interviews the manager / registered nurse and the registered nurse describe the process for ensuring service provision is based on best practice, including access to clinical nurse specialists, district health board specialists, nursing publications and nursing websites. Staff interviewed confirm understanding of professional boundaries and practice. Documentation reviewed does not consistently provide evidence that policies and procedures are based on evidence-based rationales and the improvements required are detailed in criterion 1.2.3.3.

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:**

An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed (five) provide evidence that communication with family members is being documented in residents' records. With the exception of minor adverse events, 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 manager / registered nurse advises 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 The Cottage 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. Five admission agreements are reviewed and this is 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:** PA Low

**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 manager / registered nurse and the registered nurse report informed consent is discussed and is recorded at the time the resident is admitted to the facility. Improvements are required with the management of consent documentation as residents do not give written consent for having their photograph taken for use on their clinical documentation and there is one advanced directive resuscitation form that has been signed by the resident’s enduring power of attorney (EPOA) rather than by the resident (see criterion 1.1.10.4)

Copies of legal documents such as EPOA for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident files.

Staff interviewed (four caregivers, the manager / registered nurse and the registered nurse) demonstrate a good understanding of informed consent processes.

Residents (four) and family (three) 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 (five rest home) reviewed demonstrate residents' admission agreements are signed. Staff education programme includes education on the Code of Rights and was last provided in December 2013.

Not all of 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The manager / registered nurse and the registered nurse report informed consent is discussed and is recorded at the time the resident is admitted to the facility. General consents are collected for information sharing, treatment and outings however the consents do not include consent for having the resident’s photograph taken. The advance directives include the decision to resuscitate or not. One of the files reviewed has the ‘not for resuscitation’ decision signed by the enduring power of attorney (EPOA) rather than the resident. This was corrected during this audit.

**Finding:**

i) General consent forms do not include consent for having the resident’s photograph taken.

ii) The advance directives include the decision to resuscitate or not however one of the files reviewed has the ‘not for resuscitation’ decision signed by the enduring power of attorney (EPOA) rather than the resident.

**Corrective Action:**

i) The service to obtain consents for taking photographs of residents.

ii) The ‘not for resuscitation’ decision to only be signed by a resident who is competent.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed. There is an independent advocate who visits the facility weekly and visits residents.

Resident meetings are held monthly and minutes are reviewed. 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 Rights and that advocacy and complaint management was 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, for example visitors are required to sign in and out via a register. The activities programme 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 to take residents on community visits. Some residents go out independently on a regular basis.

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 and there is one complaint recorded for 2014 (staff versus staff) and four for 2013. Review of staff/quality meeting minutes, Trust meeting minutes and the monthly manager’s reports to the directors provide evidence of reporting of complaints.

The manager advises there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC), District Health Board (DHB), or the 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 facility provides evidence that the complaint process is readily accessible and/or displayed. Review of staff/quality meeting minutes, Trust meeting minutes and the 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:**

Opunake District Rest Home Trust is the governing body and has established systems in place which defines the scope, direction, quality goals, scope of service, mission statement and philosophy and these are reviewed in 'The Cottage Rest Home Strategic Plan 2014'. 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.

Systems are in place for monitoring of the service provided at The Cottage Rest Home (The Cottage), including regular monthly reporting by the manager to the Trust which meets monthly. The manager's monthly reports to the governing body are reviewed and include quality and risk management issues, occupancy, HR issues, and clinical indicators. Trust, staff/quality and residents monthly meeting minutes are also reviewed.

The Cottage is managed by a registered nurse who was appointed to this position in February 2010. The manager worked in a rehabilitation unit at a District Health Board for seven years prior to this appointment. The manager is supported by a registered nurse who works three days a week for up to 20 hours a week. The manager / registered nurse and the registered nurse’s personal files and education records are reviewed and provide evidence of maintaining knowledge and current practice and both have current annual practising certificates.

The Cottage is certified to provide rest home level care and has contracts with the DHB to provide aged related residential care - rest home, residential respite - rehabilitation support services, and long term support - chronic health conditions. The provider also has a contract with the Ministry of Health to provide residential - non aged and there is one resident aged less than 65 years of age who is funded via this contract. The Cottage also has a service agreement with the DHB to provide meals on wheels.

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 manager / registered nurse be absent. The registered nurse fills in for the manager / registered nurse if they are absent is interviewed during this audit. The chairman of the board of trustees is also available for support if required. An office administrator works 15 hours a week and provides administration support.

Services provided meet the specific needs of the resident group within the facility. Job descriptions and interviews of the manager / registered nurse and the registered nurse confirm their responsibility and authority for their roles. The administrator is also interviewed during this audit and describes their role and their job description is reviewed.

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:**

There has been an improvement in the manner that corrective action plans are being documented following internal audits and in meeting minutes, however improvements are still required as corrective action plans are not being consistently documented (see criterion 1.2.3.8). Improvements are also required with the comprehensiveness of the policies and procedures that were implemented following the last audit (see criterion 1.2.3.3).

A written quality and risk management plan/policy identifying the organisation’s quality goals, objectives, and scope of service delivery is reviewed and includes statements about quality activities and review processes, including internal audits. Completed internal audits for 2014 are reviewed along with clinical indicators for 2014. Collated resident satisfaction surveys completed in June 2013 are reviewed and indicate acceptable levels of satisfaction. A brief letter providing feedback on these survey results to family and residents is reviewed. The satisfaction survey for 2014 is currently being completed and responses are due back to the facility by the end of July 2014. Completed questionnaires are reviewed and the majority of the responses are recorded as a ‘3’ on a scale of ‘3 to 0’ with ‘3’ being ‘always’. Completed surveys also include positive feedback on the care provided. This finding confirmed during interviews of four residents and three family members.

'The Cottage Rest Home Strategic Plan 2014' is reviewed and is used to guide the service delivery and quality programme and includes quality goals and objectives. Also reviewed documented values, mission statement and philosophy, which are displayed. Monthly staff/quality meetings are held along with monthly resident meetings. Meeting minutes reviewed and are available for review by staff. The manager is responsible for providing the trust board with monthly reports which they speak to at the monthly trust board meetings and minutes for 2014 are reviewed.

'Health and Safety/Incident Form and Accident Form', internal audits, staff/quality meeting minutes, and resident meeting minutes are reviewed. There is documented evidence in various meeting minutes that issues identified as requiring follow through are discussed at subsequent staff/quality meetings and resident meetings. Clinical indicators are recorded on a month by month 'Log of Incidents, Accidents, and Infections' and reviewed during this audit. Individual logs are also retained on each resident's file.

There is documented evidence of collection, collation and reporting of quality improvement data as well as documented evidence this data is being analysed and evaluated to identify trends. Staff interviewed (four care givers working all three shifts) report they are kept well informed of quality and risk management issues including clinical indicators. Copies of these meeting minutes are kept in the staff office for review.

There is a hazard reporting system available and a hazard register. Chemical safety data sheets available identifying potential risks for each area of service. Planned maintenance and calibration programmes in place and reviewed and biomedical equipment has appropriate performance verified stickers in place.

Not all of 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:** PA Low

**Evidence:**

The service provider introduced new policies and procedures following the last audit. These policies and procedures had previously been used at the facility but were replaced two to three years ago by ‘new’ policies and procedures that had been developed by a consultant who has no aged care experience. The manager has reverted back to the using ‘old’ policies and procedures that were first issued in August 2007. The manager has reviewed these policies and procedures and headers on these documents indicate they were reviewed in June and July 2014 (link 1.2.3.4). These policies and procedures have been signed off by the trust chairman and the manager. During interview staff advise they are updated on new/reviewed policies via meetings.

**Finding:**

Most of the policies and procedures reviewed are not comprehensive, are brief and do not provide sufficient detail to guide staff. The policies and procedures do not consistently reflect current accepted good practice and do not consistently reference legislative requirements

**Corrective Action:**

Provide evidence that: (i) the policies and procedures have been reviewed and adequate detail is included to provide guidance for staff; and (ii) the policies and procedures reflect current accepted good practice and reference legislative guidelines.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Internal audit report reviewed which is a summary of each internal audit completed, the deficiencies noted, corrective action plans required, any re-audit results (none sighted on the audits reviewed) and the manager’s signature.

Internal audit tools reviewed have sections to complete headed ‘Findings’ and “Comments’.

Meeting minute template includes space to record the issue/s, action/s, who, timeframe, completed, improvement noted.

**Finding:**

Finding:

(i)Corrective action plans following internal audits and in meeting minutes are not consistently being documented, implemented, monitored and signed off as being completed to address any shortfalls identified. (ii) Timeframes for implementation of the corrective action plans are not being consistently documented.

**Corrective Action:**

Provide documented evidence that: (i) corrective action plans are developed, implemented, monitored and signed off as completed to address any issues that have been identified as requiring improvement; and (ii) that timeframes are being recorded and monitored.

**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:**

Staff are documenting adverse, unplanned or untoward events on a 'Health and Safety/Incident Form and Accident Form'. Resident files reviewed (five rest home) provides documented evidence of communication with family and GP on the accident and incident forms, in resident progress notes, and in a 'Family Contact Record' in each resident’s file. Resident's files contain individual 'Log of incidents, accidents, infections'. Five rest home resident’s files reviewed and there is evidence that families are being contacted following adverse events involving the resident, or when there is any change in the resident’s condition.

Family members (three) 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 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). Staff also confirm they are completing accident / incident forms for adverse events.

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:** PA Low

**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 (six of six) along with criminal record vetting, employment agreements, completed orientations and a suite of questionnaires. Improvements are required with the completion of medication competency assessments (see criterion 1.2.7.5) as although care staff have completed the medicine management workbook questionnaire, not all of these have been marked and not all staff have completed a practical assessment of their competency. Copies of annual practising certificates are reviewed for the two registered nurses and other staff that require them to practice.

The manager is responsible for management of the in-service education programme 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. The manager advises there is no on-site Aged Care Education (ACE) assessor and as a result new staff are not able to complete the ACE education modules. The manager advises they are currently exploring options for providing this education either by the manager completing the training to become an on-site assessor, or by contracting an external assessor. Ten of the 15 care staff currently have completed the ACE modules or an equivalent.

Individual records of education are maintained for each staff member and copies are reviewed. An appraisal schedule is in place and 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 advises that staff are orientated for at least three shifts (morning and afternoon 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 (three caregivers working all shifts) and the registered nurse confirms they have completed an orientation. Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.

Not all of 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:** PA Moderate

**Evidence:**

Staff involved in medication management have completed a ‘Medication Administration Workbook 2014’ and these are reviewed on four of four care staff members’ files. The manager and registered nurse advise during interview that not all of these have been marked and staff have not had their practical competency assessed within the last 12 months.

Inservice planners for 2013 and 2014 are reviewed and provide evidence that education is provided at least monthly.

Attendance records are kept for each inservice education session and individual staff records are kept.

**Finding:**

Staff involved in medicine management do not have current competency assessments.

**Corrective Action:**

Provide evidence that all staff involved in medicine management have their competency assessed and that this competency assessment is completed on a regular basis.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining service provider levels (Roles and Skill Mix of Staff) which is reviewed and contains rostered numbers, staff skill mixes and other factors to be considered when determining staffing levels.

The minimum staff on duty at any one time is during the night shift (9.30pm and 6am) and consists of one care giver. A second staff member is available on the premises as a 'sleep-over' between 9.30pm and 6am. The manager/registered nurse is also on-call after hours. The manager advises they are currently reviewing the sleep-over position and it is likely that this position will become an ‘up and awake’ on duty person.

Care staff interviewed (three care givers, one RN) 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 interviewed (four) and family (three) 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 register that is appropriate to the service and is in line with the requirements of NZHIS. Interview of the manager confirms resident's data is entered on the day of admission to the facility. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed.

A visual inspection of the facility evidences that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier. Resident documentation reviewed indicates staff record their name and designation and staff sign each entry in resident documentation.

Clinical staff interviewed (three caregivers, one RN and one RN/manager) confirm they know how to maintain confidentiality of resident information. Historical records are held on site and 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:**

Entry criteria, assessment and the entry screening process is documented and communicated to residents, confirmed during interviews with four of four residents and three of three family members. The entry criteria is made available to prospective residents in the admission pack and included in the admission agreement.

The district health board 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:**

Where referral and entry to the service is declined the immediate risks for residents are managed by the manager through informing the needs assessors and referring the potential resident to a more suitable service, confirmed at the manager and registered nurse (RN) interviews and sighted record of declined services.

The district health board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Five resident files are sampled and five of five files evidence the stages of service provision developed by the staff members. The service promotes continuity of service delivery. Staff member interviews confirm residents and or their family members are involved in all stages of service provision. The long term care plans are developed by the registered nurses (RN’s) and signed by family or the resident, sighted and confirmed at three of three family interviews. Four of four residents confirm making input to their long term care plans. The sampled files evidence nursing assessments meet the appropriate timeframes and demonstrate a team approach to reviews and evaluations. There is a requirement for improvement relating to the review of medicines charts by the general practitioner as the GP need to sign and date reviews of medicines charts (Refer to 1.3.12.6). Resuscitation and consents are not signed according to requirements (Refer to 1.1.10.4).

Tracer methodology in the rest home

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

The district health board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Five of five residents' files reviewed evidence risk assessments including continence, pain, falls, mobility, nutrition, cultural and pressure area assessments, sighted. Assessments are conducted in a timely manner and risk assessment findings are recorded on residents' long term care plans. Initial care plans are completed on admission, signed by the RN and by the resident or family, confirmed at staff, four of four resident and three of three family interviews. Needs, outcomes and goals are consistent with the lifestyle plans or short term care plans, verified.

The district health board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Five of the five long term care plans are accurate, reflecting the resident's current needs and ensuring specific strategies are identified for the management of challenging behaviour, where applicable. Long term care plans are resident focussed and promote continuity of care, sighted. The long term care plans describe the required support and interventions in order to achieve the identified goals. Resident files are integrated, verified.

The district health board 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 of service delivery demonstrate that consultation and liaison is occurring with other services. Interventions are consistent with and contribute to meeting the resident’s assessed needs, sighted. Interview with the general practitioner (GP) and the RN and files sampled confirm care plans record interventions based on assessed needs and goals of the residents. The long term care plans of residents include cultural needs, sexuality and spiritual needs and the residents or family demonstrates participation in the long term care planning process by signing the care plan, verified.

The district health board 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 facility employs one activity coordinator responsible for the activities (working 25 hours per week). Four of four residents, three of three family and staff interviews confirm the activities programme includes input from external agencies, supports ordinary and unplanned / spontaneous activities including festive occasions and celebrations. Rest home residents' meeting minutes evidence residents' discussion in relation to the activities programme - sighted minutes from meetings in April and July 2014.

Five out of five residents' files sampled demonstrate the individual activities service plans are current and demonstrate support is provided. Current residents' activities assessments were sighted in all five residents' files sampled. Interview with the activities coordinator confirms the activities programme meets the needs of the service group and the service has appropriate equipment. Residents participate in the activities were sighted on the audit days. Four of four residents interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Activities attendance records are maintained and are sighted.

The district health board 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:**

Five of five residents' files sampled evidence that evaluations of long term care plans are within the timeframes and reviewed more frequently if a resident’s condition changes. Care plan evaluations are conducted by the RNs with input from the GP, confirmed at the manager, the RN and GP interviews. Family members are notified of any changes in resident's condition, evidenced in five of five residents' files sampled and confirmed at four of four residents and three of three family interviews.

There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required, verified in sampled files and during tracer methodology. Residents' files evidence referral letters to specialists and multidisciplinary reviews are current, verified. Although the GP completes reviews of the medicines charts he only ticks the chart as reviewed and does not sign or date reviewed medicines files (Refer to 1.3.12.6).

The district health board 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:**

Residents are given opportunities to choose their own general practitioner and where they will access other health and disability services, confirmed during interview with the RN, four of four residents and three of three family members. Review of the resident files confirmed residents are referred to other health and disability services, sighted referral letters to physiotherapy services, podiatrist and the dietitian.

The district health board 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 service providers identify, document, and minimise risks associated with each resident’s transition, exit, discharge, or transfer, confirmed during the interview with the manager and the RN and sighted in three resident files reviewed.

The district health board 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:** PA Moderate

**Evidence:**

The visual inspection of medication and controlled drug storage areas evidence an appropriate and secure system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks by registered nurses on a Monday. Six monthly physical stock takes of controlled drugs by the pharmacist are noted in the register. Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered, sighted during the medication round observed at lunch-time, on the first day of the on-site audit.

Ten staff authorised to administer medicines have theoretical competencies signed off, however there is a requirement for improvement relating to practical competency testing as none of the staff members complete a practical round to verify competency and the nurse manager and RN have not completed medicines management competencies (Refer to criterion 1.2.7.5).

Staff education in medicine management was conducted in April 2014. Ten medicine charts were sampled, the GP signs and dates all entries, allergies are recorded, each chart has photo identification and the GP signs, dates and crosses out discontinued medicines. At the time of the three monthly reviews of medicines the GP ticks the medicines chart however, there is no evidence of the GP signing and dating the charts at the time of review.

There is one resident who self-administers XXXXXX, the resident has not been assessed for the ability to self-administer medicines, is not monitored for taking the medicines and does not currently have a lockable draw for safe storage of the medicines.

There are three requirements for improvement regarding medicines management; staff members who administer medicines to complete a practical demonstration of their competency to administer medicines, the GP to sign and date reviews of medicines charts and the service to assess, monitor and provide residents who self-administer medicines with safe and appropriate storage for the medicines.

The district health board requirements are not fully 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:** PA Moderate

**Evidence:**

The service has one resident who self administer XXXXXX. Interview with the resident shows the resident is fully aware of the reason for using the medicines and the resident confirms carrying the medicines on his / her person. The resident has not been assessed for competency, is not monitored for administration and does not have a secure lockable area for storage of the medicines.

**Finding:**

The resident who self-administers medicines has not been assessed for competency, is not monitored and does not have a lockable draw for safe storage of the medicines.

**Corrective Action:**

The service to assess, monitor and provide residents who self-administers medicines with safe and appropriate storage for the medicines.

**Timeframe (days):** 30 *(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:** PA Moderate

**Evidence:**

There are controlled drugs stored in the facility, which is secure. The controlled drug register is maintained and evidences weekly checks on a Monday. Six monthly physical stock takes of controlled drugs by the pharmacist are noted on the register. Residents' medicines charts list all medications a resident is taking (including name, dose, frequency and route to be given). There is evidence staff are signing off, as the dose is administered. The medication round was observed during the lunch-time round on the first day of the on-site audit. Ten medicine charts were sampled, the GP signs and dates all entries, allergies are recorded, each chart has photo identification and the GP signs, dates and crosses out discontinued medicines. The three monthly reviews of medicines is conducted by the GP who ticks the medicines chart however, there is no evidence of the GP signing and dating the charts at the time of review.

**Finding:**

There is no evidence of the GP signing and dating the medicines charts at the time of review.

**Corrective Action:**

Medicines charts to be signed and dates at time of three monthly review.

**Timeframe (days):** 30 *(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. There is a seasonal four weekly menu being introduced, confirmed at the cook interview. The menu is developed by a dietitian and reviewed bi-annually, the latest review occurred during early July 2014. Food service staff members have completed food safety training in 2012. There are documented protocols for management of residents with unexplained weight loss or gain.

Food intake and monitoring forms were sighted for residents' requiring to be monitored for identified weight loss or other health reasons. Interview with the cook confirms awareness of residents who have been identified with weight loss, sighed records in the cooks file. Kitchen staff is informed if resident's dietary requirements change, confirmed at interview with kitchen staff / cook. Copies of dietary profiles were reviewed in the kitchen and in residents' files sampled. Additional snacks are available for residents when the kitchen is closed, confirmed at four of four resident interviews. Resident's nutritional needs and interventions are identified and documented on the care plan, sighted.

Residents interviewed (four of four) are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided. Food, fridge and freezer temperatures are recorded, sighted. The lunch time meal service was observed and evidences food is prepared in the main kitchen, delivered and served immediately. Staff assist resident with food intake, confirmed during three of three family interviews and sighted during the on-site audit days.

The district health board 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:** PA Moderate

**Evidence:**

There are documented processes for the management of waste and hazardous substances in place. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage (see link 1.2.3.3). Material safety data sheets are available and are accessible for staff. A hazard register is available and is current. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety and education was last provided in May 2013. Monthly visits are made by the chemical supplier representative who reviews cleaning and laundry processes.

Sluice facilities are available for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled is provided. However, improvements are required as staff are observed not using appropriate personal protective clothing when handling soiled linen (see criterion 1.4.1.6). Goggles, gloves, aprons and masks are viewed in the sluice room, 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.

Not all of 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:** PA Moderate

**Evidence:**

A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided. For example, goggles, gloves, aprons and masks are viewed in the laundry and cleaners’ room.

**Finding:**

Staff are observed not using appropriate personal protective clothing when handling soiled linen.

**Corrective Action:**

Provide evidence that staff are using appropriate protective clothing when handling soiled linen.

**Timeframe (days):** 60 *(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 alterations undertaken to an external area since the last audit that required Building Consent. The alterations include removing a wall, reconfiguring a bedroom and installing an external ramp via a fire exit door in zone 3. External plastering has not been completed yet so the South Taranaki District Council has not inspected the final work with a view to issuing a Code Compliance Certificate.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facility is fit for their purpose.

A maintenance person is employed for 20 hours a week 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 along with current calibration / performance reports for medical equipment. Electrical testing and tagging reports are reviewed. A current Building Warrant of Fitness is displayed that expires on 18 December 2014.

A visual Inspection provides evidence of safe storage of medical equipment. 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 passageway, 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. 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:**

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 weekly monthly intervals.

Toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities and there are bathrooms that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and provides working space for up to two staff members. 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

With one exception all bedrooms provide single accommodation. The manager advises the one double bedroom is only used as double bedrooms by couples. This room is viewed and adequate privacy is provided.

Visual inspection provides evidence that the bedrooms provide adequate personal space 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that adequate access is provided to the lounge and the dining room. Residents are observed moving freely within these areas. 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 (see link 1.2.3.3). There are policies and procedures for the safe storage and use of chemicals / poisons.

Care staff are responsible for management of the laundry and all linen is washed on site in the laundry. There is one door in and out of the laundry and the dirty/clean flow is adequate. Two care givers are interviewed in the laundry and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents (see link 1.4.1.6)

Cleaning staff are employed and are responsible for management of the cleaning in The Cottage. A cleaner is interviewed and describes the management of cleaning processes including the use of personal protective equipment.

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.

Visual inspection of the facility 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.

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 08 July 2009 is sighted advising the fire evacuation scheme was approved 04 June 1999. The last trial evacuation was held on 31 March 2014 (a false alarm) and the next one is scheduled for 05 August 2014.

All staff are required to complete first aid training and evidence of this is sighted on six of six staff files reviewed. 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 May 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 that is 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

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.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint approval is obtained and the service maintains a process to ensure restraint use is safe and implemented as last resort to ensure the safety of a resident, sighted restraint consent and confirmed at the restraint coordinator, RN and GP interviews. Restraint responsibilities are clearly defined. The service has one resident that currently uses a bedrail as restraint and there is no enablers being used.

The restraint is assessed, consent form is signed, the restraints are recorded in the long term care plan, risks are identified, monitoring timeframes are documented and evaluations are completed in a timely manner, sighted. The service maintains a restraint register which is up to date, sighted. The service provides education and training regarding challenging behaviour including de-escalation techniques.

The district health board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **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 service implemented a process for approving restraints including the duration of the restraint and on-going education and training, sighted training records. The responsibility of the restraint coordinator is clearly defined and there are clear lines of accountability attached to the role, confirmed at the RN interviews and sighted in the restraint policy.

The district health board 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:**

The service implements assessment processes to ensure the safe and appropriate management of restraints, sighted assessments for two restraints, the bedrail and the lap belt. Assessment of restraints include risks relating to the restraint, underlying causes for the relevant behaviour, advance directives, if the resident has been restrained in the past and, if so, an evaluation of these episodes, history of trauma or abuse, culturally safe practice, outcomes and criteria for ending restraint and alternative intervention/strategies for restraint.

The district health board 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:**

Restraints are used as the last resort in ensuring the resident’s safety, confirmed during RN, GP and the family interview of the resident using restraint. Each episode of restraint is detailed to ensure an accurate account if the indication for use of restraint, sighted restraint approval and consent records. The service implemented a restraint register recording the information relating to restraints to provide an auditable record of restraint use, sighted the restraint register.

The district health board 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:**

Each episode of restraint is evaluated with input of the RN, the GP and family of the resident, confirmed at the RN and one family interview. The service ensures that where an episode of restraint is on-going the time intervals between evaluation processes are determined by the nature and risk of the restraint as well as the individual needs of the resident, sighted restraint monitoring records.

The district health board 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 service completes three monthly reviews of restraints, sighted restraint reviews and confirmed during the RN interview. Restraint monitoring includes the time and extent of the restraint used, adverse events (incidents and accidents) relating to restraint use, review of the need for restraint use and inclusion of the restraints in the long term care plans, sighted.

The district health board 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 responsibility for infection control is clearly defined in a job description and includes the lines of accountability for infection control leading to the trust board, sighted the job description. The service has a defined infection control programme which is reviewed annually, last reviewed in 2013, sighted. The service ensures that residents and or their visitors suffering from infections are aware of the risks and the importance to prevent residents from being exposed to infections, sighted notices and confirmed during the RN and caregiver interviews.

The district health board 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 service has adequate staff and other resources to implement the infection control programme. The infection control team is the responsibility of all the staff and infections are reported on and discussed at monthly staff meetings, sighted meeting minutes and infection control reports for February to June 2014.

The district health board 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:**

The service has policies and procedures for the prevention and control of infection. Policies and procedures for infection prevention and control include current good practice (Refer to 1.2.3.3).

The district health board 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:**

Infection prevention and control annual education is provided by the infection control coordinator (ICC) and training for staff members last occurred in March 2014.Staff who could not attend the training attended IC training in June 2014, confirmed during the RN and caregiver interviews and sighted training records.

The ICC completed training relating to infection control and safe practice. The ICC is able to describe the process regarding surveillance and is able to articulate the role and the changes made in the service as a result of the data collection. Residents confirm they are aware of the importance of hand washing and are assisted by staff in maintaining good hand hygiene.

The district health board 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:**

Policies and procedures document infection prevention and control surveillance processes. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. The RN identifies trends which hare analysed and discussed at the monthly staff meetings (minutes sighted for February to June 2014).

The infection control coordinator (ICC) confirms that infections are resolved quickly also confirmed at the general practitioner (GP) interview. One resident file reviewed confirms that the doctor responded with treatment on the day of diagnosing the infection. Caregivers confirm during interview that they are aware of the need to increase fluids for residents who are suffering from urinary tract infections and that they receive instruction at handover regarding the signs and symptoms of infections.

All infections are recorded on the data collection sheets, including infections that may not be treated with antibiotics. All staff members have access to meeting minutes. Four of four caregivers interviewed confirm they have monthly meetings and that infections are discussed.

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

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

**Attainment and Risk:** FA

**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.)*