# Fraser Manor Limited

## Current Status: 26 August 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

This re-certification audit of Fraser Manor Rest Home revealed no areas of non-compliance with the Standards required and one rating of continuous improvement in quality and risk management. The service provider continues to provide rest home level care to a maximum of 32 residents. There have been no significant changes since the previous surveillance audit.in 2013. There have been no serious events.

## Audit Summary as at 26 August 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 26 August 2014

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

### Organisational Management as at 26 August 2014

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

### Continuum of Service Delivery as at 26 August 2014

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

### Safe and Appropriate Environment as at 26 August 2014

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

### Restraint Minimisation and Safe Practice as at 26 August 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 26 August 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 26 August 2014

### Consumer Rights

Care provided to residents at Fraser Manor Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Fraser Manor Rest Home currently cares for a resident who identifies as Maori and has policies and procedures to ensure culturally appropriate support is provided.

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

The local Health and Disability Advocacy Service representative attends residents’ meetings and participates in staff training. Fraser Manor Rest Home encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

Residents and relatives are advised on entry to the facility of the complaint process and demonstrate a good understanding of this process. There is evidence that all expressed concerns and/or formal complaints are taken seriously, acknowledged by the service, and then investigated and managed in ways that facilitate resolution between affected parties. The service adheres to the principles and practices of open disclosure in regards to complaints and adverse events.

### Organisational Management

Fraser Manor Rest Home is governed and operated by a private owner who purchased the service 13 years ago. The facility manager is a registered nurse who has been employed for 10 years and held the post of manager for four years. The owner is on site most days and supports the manager in ways that ensure services are well planned and coordinated to meet the needs of all residents.

Quality and risk management systems are well established and continue to be reviewed and improved upon. There is a rating of continuous improvement for ongoing adjustments to the quality system that result in better health and safety outcomes for residents and staff.

The adverse event reporting system is a planned and co-ordinated process. Staff clearly and reliably document adverse, unplanned or untoward events. Review of incident and accident reports show that all falls, skin tears, challenging behaviour and medicine errors are reported, analysed and reviewed, and then ways to reduce or prevent future incidents are discussed with staff. There is evidence families and other affected parties (eg, general practitioners) are notified of incidents where necessary, in a timely manner.

Staff are recruited and oriented according to good employer practices and all staff participate in annual performance appraisals. Staff are supported and encouraged to attend regular education and engage in professional development. There is a clearly documented rationale for determining staff levels and skill mix in order to provide safe service delivery. Rosters and interviews demonstrate that staff are allocated according to residents' needs and that staffing exceeds contract requirements. Registered nurses are onsite seven days a week. A general practitioner visits once a week depending on the residents’ needs. There is a low staff turnover.

Resident information is uniquely identifiable. Residents' files are held in a secure location and are readily accessible to staff.

### Continuum of Service Delivery

Information packs for Fraser Manor Rest Home contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with Support Net (the Needs Assessment and Service Coordination) service to ensure access to services is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate, their family.

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

Well defined medicine policies and procedures guide practice and practices sighted are consistent with these documents.

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

### Safe and Appropriate Environment

The buildings, chattels and equipment are well maintained and upgraded as required to increase resident safety and comfort. The building warrant of fitness is current. Fire suppression systems are monitored and tested regularly.

There is ample food and water and essential health care products stored on site to provide for 32 residents and staff for at least three days in the event of a civil emergency or power outage.

### Restraint Minimisation and Safe Practice

There are no residents currently requiring enablers or restraint interventions. Staff are provided with regular and ongoing education in matters related to restraint minimisation.

### Infection Prevention and Control

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

There is a defined infection prevention and control programme for which external advice and support is sought if required. The facility manager is responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

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

# HealthCERT Aged Residential Care Audit Report (version 3.92)

## **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:** | Fraser Manor Rest Home Ltd |
| **Certificate name:** | Fraser Manor Rest Home |

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

|  |  |
| --- | --- |
| **Types of audit:** | Re-certification |
| **Premises audited:** | 122 Fraser Street, Tauranga |
| **Services audited:** | Rest Home  |
| **Dates of audit:** | **Start date:** | 26 August 2014 | **End date:** | 27 August 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:** | 29 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 12 |
| **Other Auditors** | XXXXX | **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** | 4 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 24 | Total audit hours | 48 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 31 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 9 September 2014

## **Executive Summary of Audit**

**General Overview**

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**Outcome 1.1: Consumer Rights**

Care provided to residents at Fraser Manor Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Fraser Manor Rest Home currently cares for a resident who identifies as Maori and has policies and procedures to ensure culturally appropriate support is provided.

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

The local Health and Disability Advocacy Service representative attends residents’ meetings and participates in staff training. Fraser Manor Rest Home encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

Residents and relatives are advised on entry to the facility of the complaint process and demonstrate a good understanding of this process. There is evidence that all expressed concerns and/or formal complaints are taken seriously, acknowledged by the service, and then investigated and managed in ways that facilitate resolution between affected parties. The service adheres to the principles and practices of open disclosure in regards to complaints and adverse events.

**Outcome 1.2: Organisational Management**

Fraser Manor Rest Home is governed and operated by a private owner who purchased the service 13 years ago. The facility manager is a registered nurse who has been employed for 10 years and held the post of manager for four years. The owner is on site most days and supports the manager in ways that ensure services are well planned and coordinated to meet the needs of all residents.

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Staff are recruited and oriented according to good employer practices and all staff participate in annual performance appraisals. Staff are supported and encouraged to attend regular education and engage in professional development. There is a clearly documented rationale for determining staff levels and skill mix in order to provide safe service delivery. Rosters and interviews demonstrate that staff are allocated according to residents' needs and that staffing exceeds contract requirements. Registered nurses are onsite seven days a week. A general practitioner visits once a week depending on the residents’ needs. There is a low staff turnover.

Resident information is uniquely identifiable. Residents' files are held in a secure location and are readily accessible to staff.

**Outcome 1.3: Continuum of Service Delivery**

Information packs for Fraser Manor Rest Home contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with Support Net (the Needs Assessment and Service Coordination) service to ensure access to services is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate, their family.

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

Well defined medicine policies and procedures guide practice and practices sighted are consistent with these documents.

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

**Outcome 1.4: Safe and Appropriate Environment**

The buildings, chattels and equipment are well maintained and upgraded as required to increase resident safety and comfort. The building warrant of fitness is current. Fire suppression systems are monitored and tested regularly.

There is ample food and water and essential health care products stored on site to provide for 32 residents and staff for at least three days in the event of a civil emergency or power outage.

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

There are no residents currently requiring enablers or restraint interventions. Staff are provided with regular and ongoing education in matters related to restraint minimisation.

**Outcome 3: Infection Prevention and Control**

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

There is a defined infection prevention and control programme for which external advice and support is sought if required. The facility manager is responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

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

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There is a rating of continuous improvement for ongoing adjustments to the quality system which result in better health and safety outcomes for residents and staff. The manager conducts a systematic and thorough review of all quality data, such as incidents/accidents, complaints, audit results, resident and family feedback. This is clearly analysed for trends and outcomes are communicated regularly to staff and other parties involved in the residents’ care and treatment. |

# 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:**

Fraser Manor Rest Home is observed to provide an environment in which residents receive services in accordance with human rights legislation.

Management (three of three) and staff (seven of seven) are familiar with the Code of Health and Disability Services Consumers’ Rights (the Code) as evidenced during conversation with them and in sighted policy documents.

Staff receive education on the Health and Disability Commissioner’s Code at orientation and through in-service training as sighted in staff records (six of six employment, orientation and training records) and planned education programmes, and verified by interviews with staff. Residents (seven of seven) and family/whanau (three of three) interviews verify the service complies with consumer rights legislation.

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

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

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

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

Residents receive a copy of the Code in the admission information pack, with opportunities for discussion, clarification and explanation available at admission and any other time as necessary. An information booklet is also provided that outlines the services offered by Fraser Manor and how to apply for a subsidy if required. Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time. A Health and Disability Advocacy Service representative addresses residents meetings, and residents and families verify familiarity with the service. Advice on how to access the service is on a poster at the front entrance.

Advice to accessing interpreters is available through the Bay of Plenty District Health Board (DHB) should assistance be required to provide the information in a language and format that is suitable to the resident.

Staff, resident and family interviews verify residents are informed of their rights.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Safety and Abuse Policy contains clear definitions of all types of abuse and neglect and procedures for reporting actual or suspected abuse or neglect. Policy guidelines on privacy and dignity, sexuality and spirituality are contained in the consumer rights policies and meet the requirements of this standard.

Fraser Manor Rest Home provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. Bedrooms are of a size that allows appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff always knock on their door prior to entering. The nurses’ stations provide privacy of stored information. Privacy when discussion concerning residents takes place is in residents' rooms or in one of the many private lounge areas. Staff education on privacy takes place at orientation, and during in-service education.

Residents receive services that are responsive to their needs values and beliefs.

Care plans at Fraser Manor identify residents’ likes and dislikes and interventions identify the assistance the resident requires to meet residents' needs, while encouraging the resident to be as active as possible

Residents are addressed in a respectful manner and by their preferred names, are assisted to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.

Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The Individual employment agreement, House Rules, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. There are no concerns expressed related to abuse or neglect. All comments are positive.

Residents have access to visitors of their choice and are supported to access community services. Residents are noted on the day of audit to be accessing taxis and going out to attend various community activities. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident.

Staff demonstrate an awareness of the need to provide a service that is responsive to residents’ needs. Evidence of this is observed and sighted in resident and staff files reviewed and verified in resident, family and staff interviews.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Cultural Safety Policy contains extensive information about how to meet the needs of Maori residents and includes a template for cultural assessment and a Maori resident health care plan. The policy is a generic policy developed by an external provider.

Fraser Manor Rest Home recognises the special relationship between Iwi and the Crown, and appreciates that the principles of The Treaty of Waitangi (Partnership, Participation and Protection).

There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organisations model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. One of one resident, who identifies as Maori, has a comprehensive plan of care documented that supports cultural needs, as verified by file review and resident interview.

The requirements of the ARRC are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Cultural Safety Policy contains sufficient information about how to meet the needs of people from other cultures and includes guidelines on accessing interpreter services. The policy is a generic policy developed by an external provider.

Fraser Manor Rest Home provides an environment that enables residents to receive culturally safe services which recognise and respect individual ethnic, cultural and spiritual values and beliefs.

Included in the admission, and ongoing assessment process, residents and/or family/whanau are consulted about individual values and beliefs. Any special cultural, spiritual, values and beliefs requirements needed to be met by the service are identified and documented to inform the care planning and activity planning process to ensure those residents’ specific needs and objectives are met.

A multi-denominational church service is held every Monday, as sighted in the activities programme. Other requests can be arranged with management and some residents’ families access their own spiritual support from the community. Open visiting allows family/whanau to visit when they are able. Staff receive in-service training on cultural safety and the Treaty every two years.

Evidence to support findings is sighted in resident file reviews, staff training records and staff interviews. Resident and family/whanau interviews confirm staff assist residents to meet these needs.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

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

Orientation/induction processes inform staff on the Code and the house rules. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements. The facility manager will action formal disciplinary procedure if there is an employee breach of conduct.

Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date, as evidenced in staff files and verified in staff, resident and family interviews.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Fraser Manor Rest Home provides an environment that encourages good practice. All policies sighted are up to date, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales, which are monitored and evaluated at organisational and facility level.

Human resources are managed to employ competent employees. New employees complete a comprehensive orientation/induction programme that is relevant to the role being undertaken. Staff records evidence competent employment practices, orientation and training records. Fraser Manors’ management supports and encourages staff with appropriate on-going education relevant to the role they undertake. The service has an extensive and diverse in-service education programme in place which is overseen by the facility manager, who is the on-site ‘ACE’ programme assessor. Education is monitored to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. Staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management and the owner to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner.

Incident reporting systems are evidenced to be linked to open disclosure and quality improvement processes.

Three registered nurses (RNs) are employed at Fraser Manor in addition to the RN Facility Manager, enabling residents to access an RN onsite every day and on two of the seven afternoons. All care staff have or are undertaking the ACE (Aged Care Education programme) and National Certificate in Support of the Older Person. Registered Nurses and senior caregivers who administer medication have yearly assessments to determine competency (sighted). Competencies are assessed by the Manager or Clinical Manager.

Registered Nurses (RNs) and senior caregivers have an up to date first aid certificates (sighted). Ongoing education for RNs is supported by the facility and the DHB.
Kitchen staff have training in Safe Steps in Food Safety (qualifications sighted).

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

An interview with the GP verifies a high level of satisfaction with the services provided by Fraser Manor Rest Home. The service responds promptly and correctly to requests and is prompt in requesting input if needed.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

Fraser Manor Rest Home provides an environment conducive to effective communication.

Communication with relatives is documented in the progress notes in the resident’s file, and incident and accident forms evidence resident and / or family are informed of incidents, when requested. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Staff confirm they understand that relatives and residents must be informed of any changes in care provision.

There are no residents that require interpreting services, however management staff are aware of how to access interpreters if this service should be required.

Staff are identifiable by their name badge and uniforms and introduce themselves to residents upon entering the resident's room (observed).

Residents and family interviews confirm family are very involved at Fraser Manor rest home. Communication with staff is open and effective, residents and family are always consulted and informed of any untoward event or change in care provision, and are included in care reviews as evidenced in files (six of six) reviewed and verified in resident (seven of seven) and family (three of three) interviews.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Informed Consent and Resuscitation and Consent policies contain clear, detailed and extensive information on consent and options for advance directives which comply with the Code, known legislation and this standard. These policies are generic and created by an external quality consultant.

Fraser Manor Rest Home provides residents, and where appropriate their family/whanau, with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/whanau on admission. Consents requests the resident's agreement to: collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process.

Files reviewed evidence informed consent forms signed on admission and identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. Medicine charts have residents’ photographs for identification. Residents’ choices and decisions are recorded and acted on. An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non-consent to be revoked at any time. Advance directives are sighted in files reviewed. Verbal consent is obtained prior to an intervention being carried out as observed and verified in clinical staff, residents and family interviews. Written consent is obtained for invasive procedures (i.e. catheter changes). Evidence of this is sighted. Care plans are signed by the resident and/or family/whanau, where appropriate, to say they have read and agree with what is written.

Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process and confirm their understanding of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. The environment is observed to be one where choices are offered and openly acknowledged.

Resident and family interviews confirm they are provided with the necessary information to make informed choices, choices are respected by staff and staff confirm they respect the resident's right to decline consent at any time.

The consumer satisfaction survey results (sighted), indicate family/whanau satisfaction with involvement in care.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Fraser Manor Rest Home recognises and facilitates the right of residents to advocacy/support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available on a poster at the entrance to the facility. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally and are observed to go out in taxis independently. Residents and their families are aware of their right to have support persons, as verified in clinical staff, residents and family interviews. The Health and Disability Services Advocate attends residents’ meetings to keep residents informed of the service (last visit March 2014).

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Fraser Manor Rest Home provides an environment whereby residents are able to maintain links with family/whanau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges values and encourages the involvement of families/whanau in the provision of care and the activities programme actively supports community involvement and accesses community resources.

Resident and family interviews confirm that visitors can visit freely and there is free access to community services. It is observed that there were visitors coming and going from the facility during the audit with residents coming and going in taxis. File reviews, Manager, RN and the activities officer confirm community services used by the facility include:

- local social groups eg 65+

- the local community centre activities

- other aged care facilities

- local church groups and services

- the DHB nurse specialists

- the local needs assessment and service coordination agency (NASC)

- the service has a podiatrist who visits regularly

- residents have the GP of their choice

- DHB outpatient and inpatient services as appropriate.

The ARRC requirements are met

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints policy and associated processes comply with Right 10 of the Code. The policy and procedures are generic and written and developed by an external quality consultant.

The service is pro-active in ensuring residents and their families understand the complaints process and are informed about advocacy. Staff encourage residents and their families to raise any concerns or dissatisfaction at any time. The owner is on site most days and the Facility Manager /RN’s door is always open. As a result there are very few complaints. A complaints register is maintained with all concerns and complaints being logged as they come in. There are four complaints logged for 2014 and seven for 2013. There is evidence in the complaints records sampled (11 from 2013-2014) that the Facility Manager acknowledges the complaint immediately and investigates and reports back to the complainant within one to five days. There are no outstanding complaints and there have been no complaint investigations by the Office of the Health and Disability Commissioner or the District Health Board. All residents, family members and external service providers interviewed expressed a high level of satisfaction with services and confirmed they knew how to raise concerns/or complaints and said they would have no hesitation in approaching staff.

The service complies with ARC requirements for D6.2 and D13.3h.

##### **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:**

The submitted Business Management Plan contains the service scope, values, philosophy, and a range of goals and objectives for 2014. There are summaries of goal achievements for preceding years in the plan. The Quality and Risk Management Plan is aligned to the Business Plan and describes systems for service systems monitoring and review.

The Facility Manager has worked at Fraser Manor Rest Home for 10 years and has held the post of facility manager for four years. This person is a NZ registered nurse with a current practising certificate and maintains a nursing portfolio by attending regular and ongoing professional development. This is confirmed by review of personnel records and interviews with the owner and the facility manager

The owner purchased the facility 13 years ago, is on site most days, and demonstrates understanding and knowledge of the sector and contractual requirements.

The requirements of the Age Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5 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:**

The service has appropriate systems in place to ensure the day-to-day operations of the service continue should the nurse manager be absent. There are sound financial management systems and procedures and the service maintains suitable insurance liability. Services meet the specific needs of the residents. The owner and other RN are designated as temporary managers when the facility manager is absent. Interviews confirms that the manager's role is well understood and has been successfully and safely shared during planned absences. The service complies with ARC D3.1; and D19.1a

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are annual service specific business and quality goals documented. There is also a risk management plan and associated policies which meet the requirements of this standard.

Quality and risk management systems are well established and continue to be reviewed and improved upon. The facility manager is effectively managing and maintaining the quality system which is designed by an external quality consultant. There is a rating of continuous improvement for ongoing adjustments to the quality system which result in better health and safety outcomes for residents and staff. The manager conducts a systematic and thorough review of all quality data, such as incidents/accidents, complaints, audit results, resident and family feedback. This is clearly analysed for trends, and outcomes are communicated regularly to staff and other parties involved in the residents care and treatment.

There is evidence that regular internal audits of all service delivery is occurring, as confirmed by interviews and review of records. There is also evidence that quality improvements are reviewed after they are implemented to ensure the corrective actions are embedded in practice. Other documented evidence of tracking and evaluation of corrective actions is seen in the minutes of staff meetings, including the RN and health and safety meetings sampled.

Health and safety is discussed at all staff meetings (eg, monthly RN meetings and specific health and safety meetings). Planned and reactive facility maintenance occurs. There are current chemical safety data sheets for each chemical in use which are located throughout the facility. The accident /incident reporting system is co-ordinated and details are appropriately communicated to all affected parties. Specific risk assessment tools are utilised in service delivery plans to manage clinical risk. Six residents' files reviewed demonstrate that clinical risks are identified in the service delivery plans, that informed consent has been obtained and that there is multidisciplinary team input. Residents at risk of falls are clearly indicated in their records.

Identified hazards are reported and the hazard register is reviewed and updated at least annually. There are regular environmental safety inspections conducted by staff and the owner.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** CI

**Evidence:**

Quality and risk management systems are well established and continue to be reviewed and improved upon. The facility manager is effectively managing and maintaining the quality system which is designed by an external quality consultant.

**Finding:**

There is a rating of continuous improvement for ongoing adjustments to the quality system which result in better health and safety outcomes for residents and staff. The manager conducts a systematic and thorough review of all quality data, such as incidents/accidents, complaints, audit results, resident and family feedback. This is clearly analysed for trends and outcomes are communicated regularly to staff and other parties involved in the residents’ care and treatment.

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Incident Policy and associated forms clearly describe the system for reporting adverse events and includes proforma for documenting and analysing incidents and other non-conformities. The policy and forms are generic and developed by an external quality consultant. The Open Disclosure Policy meets the requirements of this standard.

There is evidence the adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. Staff record on the forms and in the progress notes when they have notified family/next of kin (NOK) of the event as they occur. Completed incident forms are held in the nurses’ office and are reviewed by the Clinical Manager and other RNs and staff immediately. The Facility Manager analyses for trends by comparing each resident and comparing data month by month. The sighted accident/incident reports for 2013-2014 and interview with the Facility Manager and the Clinical Manager about the events reporting system demonstrates a process that records the event, leads to investigation and analysis and when indicated, planning and implementation of corrective actions.

Staff are kept informed about events at shift hand-overs and through the communications book. Witnessed handovers reveal a thorough, detailed and recorded communication process. Staff have attended in-service training on open disclosure. The service complies with ARC D19.3a.vi.; D19.3b; D19.3c.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Six personnel records reviewed, including records of newly appointed staff, staff on different shifts and with different roles, show that the services uses good employment practices to recruit and develop staff. The records contain evidence of formal appointment using police checks and referee checks and records of educational achievement. The service has a very low staff turnover and most staff have been employed for more than 10 years.

New staff engage in a comprehensive orientation programme specific to their role which includes competency assessments and an appraisal 11 weeks after commencement of employment. Each RN is maintaining current first aid certificates and has a current practising certificate. Records are kept of the General Practitioners membership with the NZ Medical Council and the dispensing pharmacists practising certificate.

There is clear evidence that staff attend regular education which is related to the care of older people as per the requirements of ARC D17.6 and D17.8. The two yearly staff training calendar includes a range of relevant teaching subjects being delivered monthly by experienced trainers and there is evidence in staff files of attendance at external training and conferences. The manager attends regular education and updates related to her role as manager and infection prevention and control co ordinator as required in the ARC contract. Staff performance appraisals are occurring as required in ARC D17.7.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A staffing and skills mix policy is contained within the generic Good Employer Policy.

There are sufficient suitably skilled and qualified staff on site 24 hours a day seven days a week. This is confirmed by review of past and planned staffing rosters, interviews with the manager, RNs, caregivers, residents and relatives. The Clinical Manager works four days a week and the Facility Manager/RN Monday to Thursday. Another RN is on duty each day until 3.30pm and all RNs share on call duties so an RN is available 24 hours a day, seven days a week (24/7). There are four care givers on duty each morning plus an RN, a dedicated cook, a cleaner for three hours a day and an activities person. The owner carries out building maintenance needs and is on site most days. There are two care givers on each evening and the RN stays on until 3.30pm. There are two care givers on each night.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The observed systems for managing consumer information are safe, secure and organized. Management of consumer information meets the requirements of this standard, the ARC requirements A15.1, D7.1, D8.1 and D22 and the requirements of the Health Records Standard.

On the day of admission all relevant information (eg, initial assessment and care plan, the signed admission agreement, personal identifying information and current medicines and risks/alerts, food preferences) is entered into the organisation’s electronic system and into the resident's file. Service information is completed prior to admission if possible and if available (eg, date of birth, date of admission, full and preferred name, next of kin and contact details, gender, ethnicity/religion, national health index number (NHI), the name of the resident’s GP, authorised power of attorney and resuscitation status, known allergies, and known medical conditions and other relevant details).

The service maintains a hard copy register of admitted and discharged residents with dates and NHI numbers. All present residents have hard copy files which are stored safely and securely in the locked nurses’ station. Visual inspection of the file archive area reveals that consumer records are stored securely on site in a dry and sprinkler/fire proof upstairs area. Records sighted are stored for 10 years and are date and alphabetically categorised for easy identification and retrieval.

##### **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:**

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

Information on Fraser Manor’s bed availability, access and entry criteria, are documented and communicated to residents and their family/whanau by local doctors, referral agencies, DHB hospital, the Eldernet website and local community groups. Information includes full details of the services provided, its location, and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.

Prior to entry, the resident must be assessed by Support Net (NASC) agency in the area to ensure they require the care provided.

If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or Support Net, the local NASC agency. All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Facility Manager/owner/Clinical Manager.

Six of six files reviewed contain completed assessments by Support Net verifying placement is required. Admission agreements are signed and meet contractual requirements. Resident and family members interviewed confirm they were informed and involved in this process.

The ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

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

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

The ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Each stage of the Fraser Manor’s service is undertaken by a suitably qualified provider and is developed with the resident and their family/whanau.

Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) and includes gathering data from the resident, their family/nominated representative, the Support Net assessment and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the resident’s immediate needs.

A medical assessment is conducted by the resident’s general practitioner (GP) within 48 hours of admission or earlier if necessary and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.

Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the resident’s need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift.

The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents’ needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident’s medication is reviewed three monthly or as needs change and this is conducted by the GP, as evidenced in medication charts (12 of 12) reviewed.

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

All RNs and some caregivers have first aid certificates (sighted). Rostering evidences there are always someone on duty with a current first aid certificate. Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The clinical manager acts as the resident’s case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have qualifications in safe food handling. A contracted podiatrist provides services as required to the residents and a nail technician provides services to the residents every six to eight weeks. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

The staff turnover at Fraser Manor is very low, with senior staff at Fraser Manor having been there for longer than 10 years. The owner of Fraser Manor is on site most days and actively involved with the residents and staff, whilst also attending to any maintenance issues. The Clinical Manager oversees the care planning of all residents. Residents are attended to by their GP of choice. A verbal handover by the RN or senior caregiver occurs at the beginning of each shift to ensure all staff are familiar with the residents’ needs. Caregivers are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the residents’ progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required.

The ARRC contract requirements are met.

Tracer 1 - A rest home resident

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Within 24 hours of admission to Fraser Manor Rest Home residents have their needs identified through a variety of information sources that includes the Support Net assessment, assessments from other service providers involved with the resident, the resident, family/whanau and on-site assessments, using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested.

Over the next three weeks the Clinical Manager undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs, outcomes and goals of residents and serves as the basis for care and activity planning.

The assessments are reviewed six monthly as needs, outcomes and goals of the resident change. The Clinical Manager at Fraser Manor Rest Home has completed the interRAI training and is in the process of doing InterRAI assessments on all the residents at Fraser Manor.

A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all assessment updates and changes.

Staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The care plan at Fraser Manor Rest Home is developed in consultation with the resident and/or family/whanau and documents the resident’s individual plan of care identified by initial and on-going individual assessments and describes the required support needed to enable the resident to meet their needs, goals and desired outcome.

Residents have one set of clinical notes in which all providers involved with the residents care use to document the residents’ progress. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan. Care plans are evaluated six monthly or more frequent as the resident's condition dictates.

A short term problems page, documents the existence of short term problems and the required intervention.

Information from the assessment process informs the allied services of a resident’s needs. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer of interventions required in the activities programme, and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed and resident and family interviews verify they are included in the planning of their care. Timely access to other health providers is evident in two of the residents' files, where specialist input is required.

The staff education records sighted for six of six staff demonstrate that staff receive appropriate training. Training records evidence education that includes skin management, wound care, pressure areas, residents’ rights, continence, nutrition and hydration, restraint minimization and safe practice, elder abuse and neglect and management of challenging behaviour. The RNs participate in the in-service training and training offered by the DHB. Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are sufficiently clear and detailed clinical policies and assessment and recording forms for management of pain, incontinence, falls prevention and management, skin integrity and wounds including pressure area care, death of a resident, challenging behaviours, and grooming and personal hygiene.

The care and services at Fraser Manor are delivered in a safe and respectful manner.

The provision of care is consistent with the desired outcomes in residents’ files reviewed which document the residents’ physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.

Interviews with residents and family/whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident’s needs (sighted).

An interview with the GP states he is “extremely impressed” with the care provided at Fraser Manor. He is contacted in a timely manner when acute medical input is required and visits every week. Staff respond to his requests promptly and appropriately.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

On admission to Fraser Manor Rest Home, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident’s preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data. The residents are observed to go out and attend numerous community activities in taxis as they desire.

Activities organised reflect ordinary patterns of life and include normal community activities (eg, van outings, visiting entertainers, visits to the local community services, variety concerts, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

A fortnightly newsletter is put out by the activities officer informing residents of any “goings on”, upcoming events and outings in addition to activities on offer.

Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the residents response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.

A residents’ meeting is held every three months, and meeting minutes evidence that the activities programme is discussed. The yearly resident/relative satisfaction survey also captures feedback on the activities programme. Residents and family are satisfied with the activities offered. The activities co-ordinator interviewed reports feedback is sought from residents during and after activities.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.

Formal care plan evaluations are conducted at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan . A short term problem page is initiated for short term concerns such as infections and the resident’s general condition.

The Clinical Manager undertakes and documents all care plan evaluations, at least every six months. Short term problem plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all care plan updates and changes.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident support for access or referral to other health and/or disability service providers is facilitated to meet residents’ need at Fraser Manor. If the need for other non urgent services are indicated or requested, the GP or clinical manager sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, and where possible a family member accompanies the resident. The facility has access to a taxi van/car/taxi that can escort residents to appointments.

Residents are given a choice of GP when they are admitted. Most residents use the contracted GP who visits weekly.

Acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Exit, discharge or transfer from Fraser Manor Rest Home is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There is a specific transfer/discharge yellow envelope and blue form that records all the relative information needed when transferring a resident. If the resident is transferring to a DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes.

 The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

 The Medication Management Policy at Fraser Manor rest home identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.

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

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

The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.

The medicine prescription is signed individually by the GP. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart, as sighted.

There are some residents in the rest home who self-administer their medicines at the time of audit. The sighted assessments for self-administration is in files reviewed and meet the facility’s policy.

Medication errors are reported to the Clinical Manager, recorded on an incident form and investigated and analysed by the Facility Manager/RN with appropriate actions sighted. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in the six of six files reviewed. The Clinical Manager monitors to ensure all staff who administer medications have current competencies to ensure competency. RNs and approved senior caregivers are assessed in medication administration (documentation sighted), yearly.

Standing orders are not used at Fraser Manor.

The ARRC requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are clearly documented food, handling, storage, hygiene and preparation policies in line with current food safety practices in place at Fraser Manor Rest Home.

The food, fluid and nutritional requirements of the residents at Fraser Manor are provided in line with recognised nutritional guidelines for older people as verified by the dietitian’ s documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety.

An external provider monitors chemical use, cleaning and food safety in the kitchen and informs the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

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

Between meal snacks are available at all times in the rest home. This is sighted and verified by resident, staff and family/ whanau interview.

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

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

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

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

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policy and guidance on the safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in the waste management policy in the Infection Prevention and Control (IPC) manual. Safe storage and use of chemicals is adequately described in the food services manual and the cleaning manual. The information and descriptions meet the requirements of this standard.

Staff interviewed demonstrate awareness of safety issues around managing waste and hazardous substances. Used continence products are disposed of appropriately. The service recycles and minimises waste as much as possible. Management of waste complies with legislation and local government requirements (system observed on site). Staff are observed on audit days to be using the readily available personal protective equipment. The provider meets the requirements of ARC D19.3.v.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building and chattels are well maintained, in good repair and fit for purpose for rest home level care. Electrical testing and tagging is completed by a certified electrician every one to two years depending on the electrical appliance. All fire safety equipment is checked monthly by an external service agency . Calibrations of scales and medical equipment and checking of hoists occurs annually (evidence confirmed by interview with the owner who oversees planned and responsive maintenance and through viewing of tags on equipment and documentation in maintenance logs). There is a current building warrant of fitness which expires 23 June 2015. All hazards are reported and the hazard register is current and updated regularly (sighted). Residents using mobility aids are observed to be moving freely in all areas of the home, there are no impediments to mobilising. The external areas are safe and pleasant. Seating is safe and suitable for older people and there is sufficient shade.

##### **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 adequate and easily accessible toilets and showers. All bedrooms have hand basins. Toilets and showers are clearly identified. Some bedrooms have shared ensuite toilets and some have full ensuites. There is an adequate number of showers in each wing for the number of residents and all toilets are strategically placed. There are separate staff ablutions.

Hot water is delivered at a safe temperature in areas accessed by consumers. Temperatures from a random sample of tap sites in each wing and in the kitchen and laundry are recorded weekly. The hot water system is delivered by cylinders with tempering valves set at 45 degrees. Monitoring records reveal no temperatures over 45 degrees, except in the kitchen and laundry.

##### **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:**

Bedrooms are spacious and uncluttered. Residents with mobility aids are observed to be moving around the home and in their bedrooms with ease. All residents interviewed expressed satisfaction with their rooms and the spaces they are provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are two large lounges and smaller seating areas located throughout the home. The centrally located dining room is within easy walking distance from residents’ bedrooms. Residents and family members interviewed expressed satisfaction with the layout of the facility and communal areas.

##### **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:**

Safe and hygienic cleaning and laundry policies and procedures including job descriptions and scheduled tasks are adequately documented and described.

Interviews with the cleaning and care staff demonstrate that efficient and effective systems are in place for cleaning and laundry. There are regular internal audits and checks of the environment to ensure the effectiveness of the methods in use. All areas in the home are observed to be kept clean and hygienic. Residents and relatives are very satisfied with the cleanliness of their environments. There have been no concerns or complaints about the care of residents’ personal clothing. This is carefully laundered and ironed by care staff on each shift. Staff attend regular education on safe use of chemicals and visual inspection of all areas of the facility reveal that chemicals are safely decanted into clearly labelled containers and are stored securely.

##### **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. These clearly describe service provider/contractor identification requirements which are appropriate to the consumer group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

The New Zealand Fire Service initially approved the fire evacuation scheme in August 2005 and then confirmed this again in October 2011. Records sighted show that trial fire evacuations are occurring six monthly. An evacuation and training session with the fire service was last held on 14 August 2014. Fire suppression systems are checked monthly by an external service.

Staff interviews and review of six personnel files provides evidence of current training in emergency preparedness. Staff receive extensive information on emergency and security procedures at orientation and there is ongoing training about civil defence processes and keeping residents safe during emergencies. There is a registered nurse (RN) on call twenty-four hours a day, seven days a week and all RNs and most care staff are expected to maintain current first aid certificates. The manager ensures there is always a staff member with current first certificate on site. Information in relation to emergency and security situations is displayed for staff, residents and visitors. Emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting.

There is no generator on site but there is emergency lighting, stored torches, gas hobs and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones for use during power outages.

Call bells are accessible / within easy reach, and are available in all resident areas, (eg, bedrooms, ablution areas, ensuite toilet/showers, dayrooms, dining rooms). Staff and the cleaners conduct regular checks of these. Residents interviewed said staff respond to call bells in a timely manner.

Emergency and security systems meet the ARC requirements. The service meets the requirement of ARC D15.3e; D19.6.

##### **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:**

All bedrooms and communal areas have good natural light, safe ventilation, and effective heating. Seven residents and three family members interviewed stated the environment is maintained at a safe and comfortable temperature. The service meets the ARC requirements.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The Restraint policy is clear and comprehensive and accurately defines all types of restraint congruent with NZ8134.2:2008 RMSP standards. The policy states a rationale for a locked environment as a security measure. This applies to the front door which is only locked from the outside, anyone inside can readily and easily open the door to exit. Residents and frequent visitors have the access code for entry, and staff are also always stationed near the front door. This is a security measure, as the facility is on a busy main road with a lot of foot traffic.

There are no residents currently using restraint interventions or enablers. The restraint register shows there was one resident using bed rails for safety this year and one last year. The only restraints approved for use are bed rails, lap belts and a fall out chair. Review of six personnel records and the annual staff education plan show that staff engage in regular ongoing education in restraint minimisation, including completing questionnaires. There are clear policies and forms for assessing and managing challenging behaviour. One of the six consumer records reviewed contained a detailed and clearly described behaviour management plan. There is an annual review of all restraint use and the clinical manager is the nominated restraint co-ordinator.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Fraser Manor Rest Home provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the Infection Control Co-ordinator, who is the facility manager, to ensure appropriate resources are available (sighted) for the effective delivery of the infection control programme and it is her responsibility to implement the programme.

The infection control practices are guided by the infection control manual and assistance from the DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these is sighted at audit Reporting lines are clearly defined, as verified in staff interviews. The infection control nurse records monthly infection rate data and presents a two monthly report to RN and staff meetings (minutes sighted). The manager reports to the organisation’s management meetings any serious infection related issues. The infection control programme is reviewed annually (sighted).

An analysis of a recent Norovirus outbreak (18-26 March 2014) is sighted and verifies compliance with outbreak management policy, notification to Public Health and the Tauranga DHB.

##### **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 Facility Manager is responsible for infection control at the facility. A position description is included in the Infection Control (IC) programme and in the Facility Manager’s file.

The infection control nurse verifies there are enough human, physical and information resources to implement the infection control programme. She takes responsibility for implementing the infection control programme and has access to expert advice when required. Infection control training of the infection control nurse occurs via training offered through an external provider and in-service training (sighted).

The infection control nurse has access to diagnostic records to ensure timely treatment and resolution of infections.

The infection control nurse facilitate the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control (IC) training for staff. Any IC concerns are reported to the owner. The IC nurse reports to staff daily any IC issues at handover. IC data is collected monthly, statistics and data is analysed and reported to staff and RN meetings formally on a two monthly basis. Staff sign to acknowledge they have been informed of the data (sighted).

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

Staff interviewed (two of two care staff) are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry and kitchen staff (three of three) are observed to be compliant with generalised infection control practices.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Staff receive orientation and ongoing education relevant to their practice as verified by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.

Resident education occurs in a manner that recognises and meets the residents and the family’s communication style, as sighted in the file of a resident with a chest infection and verified by interview.

There has been a recent episode of Norovirus which has been documented and managed as per policy.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In line with Fraser Manor’s IC policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. Incidents of infections are sighted and are low. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a Registered Nurses’ meeting and staff meeting every two months where the incidents of infection are presented. A yearly comparison based on previous incidents are used as a benchmark. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. Findings are also presented at management meetings, with any necessary requirements discussed and actioned. This is evidenced by IC records and verified by staff interviews.

##### **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.)*