# Claud Switzer Memorial Trust Board

## Current Status: 1 September 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

Switzer Residential Care is certified to provide hospital (medical and geriatric) and rest home level care for up to 89 residents. On the day of the audit there were 43 hospital residents and 43 rest home residents. Switzer Residential Care’s general manager and nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented.

An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are five improvements required around policy, documentation, wound assessment, short term care planning and restraint.

## Audit Summary as at 1 September 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 1 September 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 1 September 2014

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

### Continuum of Service Delivery as at 1 September 2014

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

### Safe and Appropriate Environment as at 1 September 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 1 September 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Infection Prevention and Control as at 1 September 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 1 September 2014

### Consumer Rights

Switzer Residential Care provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents’ rights. A two yearly staff training programme supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Switzer Residential Care has implemented a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at the three monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are two required improvements around policy implementation and documentation.

### Continuum of Service Delivery

The residents and family interviews report satisfaction with the quality of care provided at the service. The service provides appropriate service for residents requiring rest home and hospital level care. The assessment, planning, provision and review of care is provided in time frames that meet the residents` needs and complies with contractual requirements. The care plans reflect the assessed needs of the residents. Where there are temporary changes in a resident`s condition the service use a short term care plan, however this was not evident in all files reviewed. This area requires improvement. The clinical policies are appropriate and the wound management policy is comprehensive. The process around wound assessment is an area identified requiring improvement. The activities programme supports the interests, needs and strengths of the residents. The residents interviewed expressed satisfaction with the activities provided and report they also have access to activities in the community. The medicine management is timely, safe and appropriate. The registered nurses are responsible for medication management and have been assessed as competent to do so. The residents expressed their satisfaction with the food service, the food is prepared on site. The menus are appropriate for the resident group and have been reviewed by a dietician.

### Safe and Appropriate Environment

The building has a current warrant of fitness and ongoing checks to maintain the building are regularly completed. Clinical equipment undergoes performance-monitoring tests. Electrical safety testing has been completed on all electrical equipment. Rooms are spacious with adequate ventilation and lighting. All hospital beds have an over bed ceiling hoists for safe transfer of residents. There is at least one staff member on each shift with a first aid certificate. Chemical management is safe and chemicals are appropriately locked away. The cleaning service is of an appropriate standard, laundry is done on site.

### Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. There is a restraint register, which also records residents who require the use of an enabler. The restraint register is current. Approved restraint is reviewed at least three monthly. The restraint approval process is undertaken with the resident and family; however, there is no recorded evidence of the involvement of other health professionals. This area requires improvement. All parties sign restraint consent forms. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. There are two residents using a chair brief as an enabler and they signed consent form for use of this. All required documentation for restraint and enabler use is recorded in the restraint folder.

### Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (senior RN) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Claud Switzer Memorial Trust Board |
| **Certificate name:** | Claud Switzer Memorial Trust Board |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Switzer Residential Care | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 1 September 2014 | **End date:** | 2 September 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:** | 86 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 17 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 17 | **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** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 34 | Total audit hours off site | 18 | Total audit hours | 52 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 23 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 10 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 20 | Total number of staff (headcount) | 100 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 2 |

## **Declaration**

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

I confirm that:

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

Dated Friday, 26 September 2014

## **Executive Summary of Audit**

**General Overview**

Switzer Residential Care is certified to provide hospital (medical and geriatric) and rest home level care for up to 89 residents. On the day of the audit there were 43 hospital residents and 43 rest home residents. Switzer Residential Care’s general manager and nurse manager are well qualified for their roles. Staff turnover remains low. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. There are five improvements required around policy, documentation, wound assessment, short term care planning and restraint.

**Outcome 1.1: Consumer Rights**

Switzer Residential Care provides care in a way that focuses on the individual resident. There is a Maori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents’ rights. A two yearly staff training programme supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

**Outcome 1.2: Organisational Management**

Switzer Residential Care has implemented a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at the three monthly meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. There are two required improvements around policy implementation and documentation.

**Outcome 1.3: Continuum of Service Delivery**

The residents and family interviews report satisfaction with the quality of care provided at the service. The service provides appropriate service for residents requiring rest home and hospital level care. The assessment, planning, provision and review of care is provided in time frames that meet the residents` needs and complies with contractual requirements. The care plans reflect the assessed needs of the residents. Where there are temporary changes in a resident`s condition the service use a short term care plan, however this was not evident in all files reviewed. This area requires improvement. The clinical policies are appropriate and the wound management policy is comprehensive. The process around wound assessment is an area identified requiring improvement. The activities programme supports the interests, needs and strengths of the residents. The residents interviewed expressed satisfaction with the activities provided and report they also have access to activities in the community. The medicine management is timely, safe and appropriate. The registered nurses are responsible for medication management and have been assessed as competent to do so. The residents expressed their satisfaction with the food service, the food is prepared on site. The menus are appropriate for the resident group and have been reviewed by a dietician.

**Outcome 1.4: Safe and Appropriate Environment**

The building has a current warrant of fitness and ongoing checks to maintain the building are regularly completed. Clinical equipment undergoes performance-monitoring tests. Electrical safety testing has been completed on all electrical equipment. Rooms are spacious with adequate ventilation and lighting. All hospital beds have an over bed ceiling hoists for safe transfer of residents. There is at least one staff member on each shift with a first aid certificate. Chemical management is safe and chemicals are appropriately locked away. The cleaning service is of an appropriate standard, laundry is done on site.

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

There is a documented definition of restraint and enablers. There is a restraint register, which also records residents who require the use of an enabler. The restraint register is current. Approved restraint is reviewed at least three monthly. The restraint approval process is undertaken with the resident and family; however, there is no recorded evidence of the involvement of other health professionals. This area requires improvement. All parties sign restraint consent forms. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. There are two residents using a chair brief as an enabler and they signed consent form for use of this. All required documentation for restraint and enabler use is recorded in the restraint folder.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (senior RN) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies, standards and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive on-going training in infection control.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 4 | 1 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.3 | The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | During the audit it was noted:  a) The health & safety and infection control committee oversee the restraint programme. There is a policy in place that meets the requirements of the standard. The policy notes the restraint process is undertaken in: Consultation with Medical personal, carers, and relatives…. There is no evidence of this process being implemented (refer evidence 2.2.1).  b) There is a policy to guide staff in the management of challenging behaviour. The policy notes that consideration should be given to completing a ‘Monitor and Review Challenging Behaviour Form’ for those residents exhibiting challenging behaviour. This form (sighted) categorizes the behaviour and totals at the end of each day. While these forms are seen in resident files, they are not completed, rather a timeline of events is recorded on an attached sheet. The behaviours recorded on the attached sheet are not transferred onto the Monitor and Review Challenging Behaviour Form (M&RCB). In addition the M&RCB does not have a category for verbal abuse. At the time of audit there was a resident exhibiting verbal outbursts.  c) There are policies to guide the reporting of incidents and accidents within the workplace – Acc.Inc.Near Miss Reporting, Accident Reporting and Investigation and Incident Reporting. The Incident Reporting policy informs an incident is: All occurrences which do not come within the field of Accidents or Near Misses, eg, Wandering Residents, Security alarms, Fire Alarms, Intruders, Infectious materials, body substances or hazardous substances. There are two reporting forms for the different events. Review of the resident reported accident and incidents for August shows 12 resident events recorded on an incident form and 30 on an accident form. The 12 events recorded on the incident form do not consistently meet the policy definition. The service informs they are in the process of reviewing the forms associated with these policies. In addition, the categories on the two forms being used do not include clinical indicators such as medication errors, pressure areas and bruising. The monthly monitoring/trending data records these events in an ‘other’ category making month-by-month trending difficult to monitor – it is acknowledged these indicators are included as part of the Far North Benchmarking Group. | Align policy and practice. | 180 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | In two of five rest home resident files reviewed updating of progress notes was outside of the prescribed timeframes – in file one there was no entry for eight to 12 days (the resident had been charted antibiotics during this time), and in file two there had been no entry for 12 to 19 days. | Progress notes are updated within prescribed timeframes. | 30 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Information on the wound assessments and wound management documentation is incomplete. This include: a) three of six hospital residents documentation do not have the date of onset nor the type of wound recorded, b) six of eleven rest home residents documentation do not have the date of onset the type of wound or the review date. | Ensure wound assessment documentation and management plans are completed according to the information provided on the document | 60 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Low | Short term care plans were not completed for the following residents: a) a rest home resident XXXXX b) a rest home resident with XXXXXXXX; c) a rest home resident with XXXXXXd) a hospital resident XXXXXX e) a resident with XXXXX; f) one hospital residents with a XXXX and g) two rest home residents XXXXX. | Ensure short term care plans are utilised and completed for: i) all short term care issues for example UTI`s and ii) short term or acute wounds. | 90 |
| HDS(RMSP)S.2008 | Standard 2.2.1: Restraint approval and processes | Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | PA Moderate |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.1.1 | The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Moderate | (i) Risk assessments are not completed consistently with other clinical assessments for example: one hospital resident last risk assessment was done in 2012; however, her cognitive ability has deteriorated since; ii) five files (hospital level) lack evidence that discussions of risks and restraint use happens on multidisciplinary level | Ensure a) restraint approval process is a multidisciplinary approach and evident in documentation; b) Risk assessments are consistently reviewed with other clinical assessments | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Switzer Residential Care has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about abuse and neglect and advocacy services that includes the Code, at orientation and as part of the two yearly in-service programme. Interview with five health care assistants (who work across rest home and hospital) demonstrate an understanding of the Code. Elder abuse training was provided May 2014. Residents interviewed (three rest home and five hospital) and relatives (three rest home and three hospital) confirm staff respect privacy, and support residents in making choice where able.

##### **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:**

There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed through the facility. The monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents interviewed (three rest home and five hospital) and relatives (three rest home and three hospital) inform information has been provided around the Code. The general manager and nurse manager inform an open door policy for concerns or complaints.  
D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission. The general manager, nurse manager and registered nurses describe discussing the information pack with residents/relatives on admission.   
D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

##### **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:**

There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Resident files are stored out of sight. Staff could describe aspects of abuse and neglect, and informed recent training on the topic (May 2014). Relatives (three rest home and three hospital) interviewed stated that the care provided is very good and staff are respectful. A satisfaction survey is completed annually (June 2014). The June survey informed 95% of respondents feel staff are courteous and friendly, and 71% inform they are given the assistance they require. Residents are also asked about satisfaction with food and are able to contribute ideas for the menu.  
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with five health care assistants (who work across rest home and hospital) describe how choice is incorporated into resident cares. Interview with residents (three rest home and five hospital) and relatives (three rest home and three hospital) inform staff are respectful. There is an abuse and neglect policy being implemented and staff attend in-service (May 2014). Interviews with residents and family members were extremely positive about the care provided.  
D4.1a: Ten resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with residents confirm their values and beliefs were considered.   
D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality  
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files

##### **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:**

A3.2 Switzer Residential Care has a Maori Health Plan (2012-2014) that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan (three of three Maori resident files reviewed). At the time of audit the staff report there are approximately 16 residents that identify as Maori – interview with two Maori residents informed their cultural needs are met.

D20.1i There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

The service demonstrates a philosophy of continuous improvement across aspects of service delivery such as a quick reference flip chart providing guidance for staff on culturally acceptable practice: “Claud Switzer Memorial Trust – Tikanga Recommended Best Practice Standards/Guidelines” (November 2012). The flipchart includes seven standards and cover the following aspects: karakia; taonga/valuables; information and support; whanau/family support; food, linen and bedpans; body parts/tissues/substances and pending and following death. Each standard includes a summary in a series of dot points describing best practice. The working group developed a culturally appropriate design for the flipchart and tested the content with Te Hiku – a local health provider.

##### **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 resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives (three rest home and three hospital) inform values and beliefs are considered. Residents interviewed (three rest home and five hospital) confirm that staff take into account their culture and values.  
D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.   
D4.1c Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs.

##### **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:**

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur three monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the nurse manager and five registered nurses confirm an awareness of professional boundaries. Interview with five health care assistants (who work across rest home and hospital) could discuss professional boundaries in respect of gifts.

##### **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:**

Switzer Residential Care has a suite of appropriate policies and procedures that are updated as necessary. There is an established quality improvement programme that includes performance monitoring against clinical indicators. Switzer Residential Care is part of the Far North Quality and Benchmarking Group that is make up of five residential facilities within the region. Benchmarking is undertaken against prescribed indicators including (but not limited to): medication errors, pressure injuries and challenging behaviour. The purpose of the benchmarking group is not only to compare clinical indicator data, but problem solve similar issues (refer evidence 1.2.3).

There is an active culture of ongoing staff development with the ACE programme being compulsory. There is an education coordinator (RN) who works 20 hours/week and is the ACE assessor. There are an estimated 20 (of 56) staff with national certificates with the remaining 36 working towards the qualification. There is evidence of education being supported outside of the biannual training plan such as palliative care training for health care assistants and attendance at in-service offered via the DHB and/or PHO/s. There is a ‘train the trainer’ programme in place that includes a 16 week in-service programme – the healthcare assistants spoke very positively about the programme.  
  
ARC A2.2 Services are provided at Switzer Residential Care that adhere to the health & disability services standards.   
ARC D1.3 all approved service standards are adhered to.   
ARC D17.7c There are implemented competencies for healthcare assistants and registered nurses including but not limited to: medication and manual handling. RNs have access to external training.   
  
Residents interviewed (three rest home and five hospital) and relatives (three rest home and three hospital) were positive about the care they receive. Interview with five health care assistants (who work across rest home and hospital) inform they are well supported by the RN’s and management team.

##### **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:**

There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twenty-five forms reviewed across August identify family were notified following a resident incident, an additional 10 incident forms did not notify family, noting there is evidence in resident files that family do not wish to be informed of ‘minor’ incidents. Interview with five health care assistants (who work across rest home and hospital) and five RN’s inform family are kept informed.  
  
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry  
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b relatives (three rest home and three hospital) stated that they are informed when their family members health status changes.  
D11.3 The information pack is available in large print and this can be read to residents.

##### **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:**

Policies and training support staff in providing care and to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with five health care assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, photographs, restraint and provision of care. All ten resident files (five from the rest home, five from the hospital) reviewed have consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in ten resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented. An EPOA for one resident in the rest home has been recently activated, a medical certficate was evidence to be attached to the document.

D13.1: Ten (five from the rest home, five from the hospital) admission agreements had been signed on the day of admission.

D3.1.d: Discussion with six family members (three from the rest home, three from the hospital) identified that the service actively involves them in decisions that affect their relative’s lives.

##### **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:**

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the general manager and nurse manager confirm practice. Residents interviewed (three rest home and five hospital) confirm that they are aware of their right to access advocacy.  
D4.1d; Discussions with relatives (three rest home and three hospital) confirm that the service provides opportunities for the family/EPOA to be involved in decisions   
ARC D4.1e. The resident files include information on residents’ family/whanau and chosen social networks.

##### **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:**

D3.1h: Interview with eight residents and five relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Residents interviewed (three rest home and five hospital) confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.  
D3.1.e Discussion with five health care assistants (who work across rest home and hospital), the diversional therapists, six relatives and eight residents confirm residents are supported and encouraged to remain involved in the community and external groups.

##### **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 to guide practice. The general manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) log/register that records activity in an ongoing fashion. Complaints are discussed at the monthly quality meeting. Complaints forms are visible around the facility on noticeboards. There have been six complaints during 2013 and three during 2014 (to date). The 2014 complaints were reviewed and all have been investigated and closed out. The general manager (who is also the quality coordinator) completes a six monthly review of complaints and trends as part of the quality programme (the review for January to June was sighted). Discussion with eight residents and six relatives confirm they are aware of how to make a complaint.   
D13.3h. a complaints procedure is provided to residents within the information pack at entry

##### **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:**

Switzer Residential Care provides care for up to 88 residents across two service levels (rest home and hospital) at the time of audit. The service is currently building a 15 bed dementia unit – tentative completion December. Due to the building programme one resident room is unavailable reducing the previous 89 beds to 88 during this audit. Relevant agencies are aware of the pending dementia unit.

The 89 (including the currently unavailable bed) beds comprise 43 rest home, 30 hospital and 16 dual-purpose beds. On the day of audit and there were 43 rest home residents and 43 hospital level residents – one of which was respite. Included in these numbers is one younger person who is rest home level and one rest home resident who has been assessed as requiring dementia level care and is currently waiting placement.   
  
Switzer Residential Care is a charitable trust with a board of trustees (three). There is an advisory group – that includes a kaumatua – who meet with the board of trustees quarterly. The facility is managed by a general manager (registered nurse) with a current annual practising certificate) who has been in post 16 years. The general manager meets monthly with the board of trustees. There is a strategic plan (2013-2016) that includes long term goals, vision, mission and philosophy. Goals include critical success factors and outcomes. Examples of goals include: to provide a range of services to meet the needs of diverse older people with priorities including completion of the dementia unit and additional hospital beds. There is an annual business, quality improvement and risk management plan (July 2014) that details the quality programme such as audit schedule, surveys management of complaints and the like. Benchmarking is undertaken as part of the Far North Quality & Benchmarking Group. The group meet three monthly.  
  
The service is managed by an experienced registered nurse who has been the general manager at Switzer Residential Care for 16 years and is supported by a nurse manager who has been in post five years – she was previously a registered nurse at the facility. There is a team of registered nurses who have experience within the aged residential care environment. ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

##### **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:**

During a temporary absence, the nurse manger will cover the general manager’s role (and vice versa). Both the general manager and nurse manager are experienced registered nurses.   
D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Switzer Residential Care is implementing a quality and risk management system. Policies are reviewed on a regular basis – review dates are recorded in the footer on policy documents. There are examples where policy is not consistently being implemented and this is a required improvement.

Quality matters are taken to the monthly QA meetings that comprise a core group of staff. QA meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends). The quality coordinator is the general manager. Monthly accident/incident reports, infections and results of internal audits are completed. Monthly meeting minutes are included in the board ‘packs’ to keep them appraised of clinical/operational matters/risk/initiative. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.

Switzer Residential Care infection control and health & safety matters are included as part of the monthly quality meetings and include discussion around the number and type of infections and health and safety matters – such as staff accidents. Information is fed back to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (monthly). Switzer Residential Care is implementing an internal audit programme that includes aspects of clinical care – such as documentation review. Issues arising from internal audits are recorded as having been resolved with implementation reviewed at the next scheduled audit. There are a small number of corrective action plans (signed and closed out) on file. InterRAI is being implemented.

The service strives to maintain effective communication through the facility which has seen the establishment of a ‘team communicators’ meeting structure (in place over two years). This involves a representative from each wing and each department. The group meet monthly (minutes sighted) and it is the responsibility of the representative to feed information back to the respective teams. The representatives from the wings are healthcare assistants (interviewed three), who are paid a higher rate in acknowledgement of the additional responsibility. The healthcare assistants interviewed informed this forum provides the opportunity to have involvement in service matters. The meeting is facilitated and minuted by the human resources manager (interviewed). The manager reports this structure essentially ‘equalises’ all staff groups and supports distribution of relevant information. The service completes staff newsletters three monthly (sighted April and July 2014), and an annual staff survey. Results from the staff survey reports 95% of staff who completed the 2014 survey feel part of an effective team, and 100% are proud to work for Swtizer. There is also a staff forum that is run by staff for staff, these forums are to be ‘relaunched’. Staff are encouraged to make suggested improvements to the service using ‘Improvements to our Work Areas’ form (sighted).

Switzer is in the process of implementing a number of quality improvements such as review of pressure areas (project start date May 2013), falls prevention – with the objective to reduce falls by 12.5% (start date July 2013) and a large project well underway around assessment and care planning/documentation. The service has just commenced training to become an Eden facility.

D19.3: There is a comprehensive H&S and risk management programme in place including policies to guide practice. The facility manager is the health and safety coordinator for the facility who monitors staff accidents and incidents. The hazard register is reviewed annually – last completed April 2014.  
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hi/lo beds, assessment and exercises by the physiotherapist (interviewed) and sensor mats.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Switzer has a suite of policies to support service delivery which are reviewed at regular intervals.

**Finding:**

During the audit it was noted:

a) The health & safety and infection control committee oversee the restraint programme. There is a policy in place that meets the requirements of the standard. The policy notes the restraint process is undertaken in: *Consultation with Medical personal, carers, and relatives….* There is no evidence of this process being implemented (refer evidence 2.2.1).

b) There is a policy to guide staff in the management of challenging behaviour. The policy notes that consideration should be given to completing a *‘Monitor and Review Challenging Behaviour Form’* for those residents exhibiting challenging behavior. This form (sighted) categorizes the behavior and totals at the end of each day. While these forms are seen in resident files, they are not completed, rather a timeline of events is recorded on an attached sheet. The behaviors recorded on the attached sheet are not transferred onto the Monitor and Review Challenging Behaviour Form (M&RCB). In addition the M&RCB does not have a category for verbal abuse. At the time of audit there was a resident exhibiting verbal outbursts.

c) There are policies to guide the reporting of incidents and accidents within the workplace – Acc.Inc.Near Miss Reporting, Accident Reporting and Investigation and Incident Reporting. The Incident Reporting policy informs an incident is: *All occurrences which do not come within the field of Accidents or Near Misses, eg, Wandering Residents, Security alarms, Fire Alarms, Intruders, Infectious materials, body substances or hazardous substances*. There are two reporting forms for the different events. Review of the resident reported accident and incidents for August shows 12 resident events recorded on an incident form and 30 on an accident form. The 12 events recorded on the incident form do not consistently meet the policy definition. The service informs they are in the process of reviewing the forms associated with these policies. In addition, the categories on the two forms being used do not include clinical indicators such as medication errors, pressure areas and bruising. The monthly monitoring/trending data records these events in an ‘other’ category making month-by-month trending difficult to monitor – it is acknowledged these indicators are included as part of the Far North Benchmarking Group.

**Corrective Action:**

Align policy and practice.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the integrated meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse at the time of event and the form is forwarded to the nurse manager for final sign off. Family are notified. 11 incident forms reviewed included RN review and sign out. Preventative strategies were recorded. Interview with staff (five healthcare assistants and five registered nurses) inform incidents/accidents are reported appropriately.  
  
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered and reported through the Health & Safety and Infection Control meeting (and then on to the quality meeting/team communicator meetings) (refer evidence 1.2.3).  
  
Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. The infection control coordinator reported a norovirus in 2013, relevant notifications were seen to have been made.

##### **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:**

There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Ten staff files were reviewed (two registered nurses – one who is the infection control coordinator and restraint coordinator, four healthcare assistants, chef, diversional therapist, laundry and enrolled nurse) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.  
  
The service has an education coordinator who is responsible for ensuring the orientation programme is completed for new staff. There is a buddy system for new staff (healthcare interview), and a ‘train the trainer’ programme being implemented. Staff interviewed (five healthcare assistants, five registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service. They informed the period that a new staff member is buddied can be extended if needed.  
  
There is a two yearly education plan that includes all required education as part of these standards. The plan is coordinated by the education coordinator and is seen to be implemented. Compulsory study days are offered every second month and staff are required to attend one day annually. These days are called ‘make it happen’ and include the following topics: falls prevention, fire evacuation/training, occupational health and safety, code of rights, infection control and resuscitation. Staff are able to make suggestions on additional topics for inclusion in the in-service calendar (interview five healthcare assistants, team communicator meeting minutes). There is evidence that additional training opportunities are offered to staff such as attendance at a palliative care series. Training attendance is recorded on a database (sighted), and the education coordinator undertakes a reconciliation of attendance annually (June 2014), this process ensures staff are meeting compulsory requirements (from the information reviewed all staff have attended a ‘make it happen’ study day within the last year). There is evidence on registered nurse (RN) staff files of attendance at the RN training day/s and external training. Interview with five healthcare assistants confirm participation in the ACE training programme is compulsory. There is an estimated 20 (of 56) staff with national certificates and the remaining 36 are progressing towards a qualification. A competency programme is in place with different requirements according to work type (e.g. healthcare assistant, registered nurse, and kitchen). Competencies are completed and a record of completion is maintained in the database. Medication competencies are completed for registered and enrolled nurses and are current at the time of audit. Staff interviewed are aware of the requirement to complete competency training. Formalised phlebotomy training is due to be implemented.  
There is a staff member with a current first aid certificate on every shift (17 staff hold a current first aid certificate).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager (registered nurse with current annual practising certificate) and nurse manager alternate on-call. The activities staff (two) work Monday through Friday. The healthcare assistants, residents and relatives interviewed inform there are sufficient staff on duty. There is at least one registered nurse and one first aid qualified person on each shift. Staffing is as follows: one registered nurse on AM, PM and ND seven days, two healthcare assistants – respite and orderly – that are not allocated to a particular wing but assist according to need; and in addition:

Kowhai (23 hospital): AM: 1xenrolled nurse (EN)/RN, five healthcare assistants various times; PM: 1xEN/RN (1300-2100), five healthcare assistants

Puriri (four hospital, nine rest home): AM: two healthcare assistants (various times); PM: two healthcare assistants

Matai (four hospital, ten rest home): AM: two healthcare assistants (various times); PM: one healthcare assistant

Kauri (18 rest home): AM: two healthcare assistants (various times); PM: one healthcare assistant

Millie (16 hospital): AM: 1xRN/EN, two healthcare assistants (various times); PM: two healthcare assistants (various times)

Night Duty – across the facility: 1xRN, four healthcare assistants

##### **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:** PA Low

**Evidence:**

The resident files are appropriate to the service type. In two of five rest home resident files entries in the progress notes were outside of prescribed timeframes and this is a required improvement. An initial care plan is developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant healthcare assistant or registered nurse including designation. Policies contain service name.

##### **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:** PA Low

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time.

**Finding:**

In two of five rest home resident files reviewed updating of progress notes was outside of the prescribed timeframes – in file one there was no entry for eight to 12 days (the resident had been charted antibiotics during this time), and in file two there had been no entry for 12 to 19 days.

**Corrective Action:**

Progress notes are updated within prescribed timeframes.

**Timeframe (days):** 30 *(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:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. NASC assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the residents level of care requirements. There is a comprehensive information pack provided to all residents and their families for rest home, hospital and acute GP care. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. Eight residents (three from the rest home, five from the hospital) and six family members (three from the rest home, three from the hospital) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Ten resident files (five from the rest home, five from the hospital), were reviewed. Ten had NASC approval and signed service agreements.

D13.3: The admission agreement reviewed aligns with a) - k) of the ARC contract.

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

D14.1: Exclusions from the service are included in the admission agreement.

D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

##### **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:**

There is a declining entry section in the admission procedure. The service records document the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The general manager explains the reasons for recent declining of entry and the register was sighted.

##### **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:**

There is a policy that describes resident’s admission and assessment procedures. A registered nurse undertakes the assessments on interRAI, with the initial support plan completed within 24 hours of admission. Activity assessments and the activities sections in care plans have been completed by the diversional therapist. The collection of the information and data is a collaborative effort with the resident and relatives. Clinical assessment protocols (CAP) are triggered by the interRAI process, with a printed version in the resident file. Separate assessment tools are completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) nutritional assessment and g) pain assessment. Care plans are used by nursing staff and healthcare assistants to ensure care delivery is in line with the residents assessed needs. Cultural needs, social/spiritual, sexuality and intimacy, medication management and restrain management are addressed seperately that were not triggered by the interRAI. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change).

A verbal handover at the end of the morning shift was observed that maintains continuity of service delivery. All ten files identified integration of allied health including district nurses, oncology, DHB nurse specialist, geriatricians,pshyciatric services for older people, physiotherapy and podiatry. The two GPs interviewed spoke very positively about the service and describe effective communication processes. Also refer 1.2.9.1.

D16.2, 3, 4: The ten resident files reviewed (five from the rest home, five from the hospital), identified a nursing assessment was completed within 24 hours and that the long term care plan was completed within three weeks.

There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Ten care plans reviewed evidence evaluations completed at least six monthly. None of the sample residents had been in the facility less than six months.

Tracer Methodology rest home

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

Tracer Methodology hospital:

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:**

A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified through the interRAI assessment tool. Information and data are collected through a collaborative effort with the resident and /or relatives.The clinical assessment protocols of interRAI guides the care plan. A range of assessment tools are completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. Separate issues including nutrition, social needs/spirituality and cultural needs are assessed on admission and as needed. Weights and BP's are monitored on a weekly to monthly basis dependant on needs. Three residents with behaviours that challenge were reviewed from the hospital. Assessments are conducted in an appropriate and private manner. All residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Eight resident interviews (three from the rest home, five from the hospital), and six family members (three from the rest home, three from the hospital), state they are informed and involved in the assessment process.

##### **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:**

Residents' files include; InterRAI initial assessment, daily progress notes, BP and weight recordings, short term care plans, long term care plans, risk assessments, regular evaluations, GP initial assessment and visits, lab results, NASC assessment, allied health reports, activities, consents, advance directives, letters, referrals and admission agreements. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. All ten care plans reviewed were evidenced to be up to date. Goals and outcomes are identified and agreed and how care is to be delivered is explained. All rest home and hospital residents have an individualised long term care plan that covers all areas of need identified through the interRAI assessment. Areas covered in the ten resident files (five from the rest home, five from the hospital), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, activites of daily living, nutrition, social needs/spititual, intimacy and sexuality and medication management. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, geriatrician, oncology, DHB nurse specialist, physiotherapy, psychiatric services for older people and podiatry. There is evidence that residents are seen by their GP at least monthly. There is a separate authorisation form completed by the GP should the resident`s clinical status only requires a three monthly visit. The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families are well documented.

D16.3k: Short term care plans are not always utilise for short term acute changes in health status(link imporvements 1.3.8.3).

D16.3f: Ten resident files reviewed identified that family were involved.

##### **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:** PA Low

**Evidence:**

The service provides services for residents requiring rest home and hospital level care. Care plans are completed comprehensively. Ten resident files (five from the rest home, five from the hospital), were reviewed for this audit.

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Care plans evidenced at least six monthly care plan reviews. Overall, the care being provided is consistent with the needs of residents, this is evidenced by discussions with five healthcare assistants, six family members (three from the rest home, three from the hospital), five RN’s, three EN`s, the nurse manager (RN) and the general manager. The two GPs interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and residents primary care is provided by their own GP. There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses ,geriatricians and pschyciatric services for the older person. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and the treatment rooms are stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management and toileting regimen. Continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Wound assessment and wound management plans are in place for 17 residents with wounds. Three residents have pressure areas recorded (grade 1 and 2). However information on the wound assessments and management plan documents are not always completed. This on interview the five RN’s and the nurse manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence of the wound specialist referrals.

##### **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:** PA Low

**Evidence:**

Wound assessment and wound management plans are in place for 17 residents with wounds. Three residents have pressure areas recorded (grade 1 and 2). Information on the wound assessments and management plan documents are not always completed however, wound dressings occur within stated timelines. On interview the five RN’s and the nurse manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence of the wound specialist referrals. One resident in the rest home has complex wounds with evidence of regular input from a nurse specialist.

**Finding:**

Information on the wound assessments and wound management documentation is incomplete. This include: a) three of six hospital residents documentation do not have the date of onset nor the type of wound recorded, b) six of eleven rest home residents documentation do not have the date of onset the type of wound or the review date.

**Corrective Action:**

Ensure wound assessment documentation and management plans are completed according to the information provided on the document

**Timeframe (days):** 60 *(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:**

Two diversional therapists employed by the service have worked at the facility for more than 6 years and each works 32 hours over five days. The diversional therapists stated that weekend activities are facilitated by the health care assistants. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. A “Map of life “ is available in each resident`s room that reflects the particular resident`s interests. The five health care assistants and two diversional therapists interviewed confirm that the tool help them to initiate meaningful conversations with the residents. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo, movies and outings. There are also visits from community groups. All six family members (three from the rest home, three from the hospital), interviewed stated that activities are appropriate and varied enough for the residents. All eight residents (three from the rest home, five from the hospital), interviewed stated they were happy with the activities available and are given a choice regarding attendance. Diversional therapists interviewed, stated resident association meetings are held once a month. Family members are welcome, usually it is an open agenda but they do focus on one resident each month. This was confirmed by one hospital resident and her daughter. Healthcare assistants were observed various times during the day diverting a hospital resident from behaviour that is challenging.

D16.5d: Ten resident files reviewed identified that the individual activity plan is reviewed when at care plan review

##### **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:** PA Low

**Evidence:**

All initial care plans were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. The interRAI assessment tool guides the care plan. One RN stated that the interRAI is limited with the ability to fully evaluate care and that evaluation of care continues on the care plans. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all ten care plans reviewed. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes. On interview the nurse manager confirmed that the use of short term care plans became a focus in the last six months. The use of short term care plans are evident in some files however, short term care plans are not used consistently for acute short term health care changes. This is a required approvement.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

##### **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:** PA Low

**Evidence:**

The change in health care status are recorded in the progress notes and changes are made to the care plan. The use of short term care plans are evident in some files but are not use consistently for all acute short term issues. On interview, the nurse manager confirmed that the service started to focus on the use of short term care plans in the last six months. There is a file and register available for RN`s to refer to for all residents with short term care issues.

**Finding:**

Short term care plans were not completed for the following residents: a) a rest home resident with a XXXXXX; b) a rest home resident with XXX and XXXXX for five days; c) a rest home resident with a XXXX with clear instruction for the next 72 hours; d) a hospital resident with an XXXXX; e) a resident with acute XXXX; f) one hospital residents with a XXXXX and g) two rest home residents with XXXX.

**Corrective Action:**

Ensure short term care plans are utilised and completed for: i) all short term care issues for example urinary tract infections (UTI)`s and ii) short term or acute wounds.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. Referral forms and documentation are maintained on resident files. There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. Follow up occurs as appropriate.

D16.4c: The service provided an example of when a resident’s condition had changed and the resident was reassessed for a higher level of care. Currently one resident is assessed as needing specialised dementia care and is waiting for an available bed.

D 20.1: Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, district nurses, podiatrist and physiotherapy services

##### **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:**

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident’s file. This was sighted in two resident files transferred to hospital. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. On the day of the audit a rest home resident was transferred to the DHB for admission; the process of transition , transfer and communication was observed. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

##### **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:**

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by two RN`s. Any mistakes by the pharmacy are regarded as an incident. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 20 medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms. There is a locked cupboard that is used for controlled drugs. There are drug trolleys that are kept in the nurses’ station which are locked when not in use. Medication round observed; all practice is appropriate. A medication competency has been completed annually by all staff who administer medication. There is a policy and process that describes self-administered medicines. There are currently five residents who self-administer their inhalers. All five residents have a current competency check, this is reviewed three monthly by a RN. The residents keeps a record of when they administer the medication and this is reviewed and checked by a RN.

D16.5.e.i.2: twenty medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs a two chefs to provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of food and the kitchen can cater to specific requests if needed. An RN completes each residents nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen;updates are communicatedback to the kitchen should this occur. Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented. The service encourages residents to express their likes and dislikes. The residents interviewed confirm that they enjoy the meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the three fridges and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away. Food audits are carried out as per the yearly audit schedule. Documents evidence input from a registred dietitian. As part of a move toward the Eden phiolosphy there are three residents setting the tables during meal times.

D19.2: Kitchen staff have been trained in safe food handling.

##### **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:**

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency manual available to staff which includes hazardous substances,five health care assistants, five RN’s, nurse manager and one facility manager interviewed were able to describe hazard management. There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical training occurs annually. All chemicals sighted were appropriately labelled and stored in locked areas. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

##### **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 holds a current warrant of fitness which expires in June 2015. Reactive and preventative maintenance is documented and implemented. The facility manager confirms that the current building improvements have a minimal impact on the service and the residents. The residents have no access to the building renovations; regular updates are displayed on the notice boards. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts contractors; the issue can usually be repaired or resolved on the same day. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. One section of a wing had a shower temperature of 58 degrees in May 2014, corrective actions were applied immediately and the follow up temperature was recorded and maintained below 45 degrees.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest homeand hospital. All hospital beds have an overbed ceiling hoist. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident’s bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, shower trolleys, heel protectors, lifting aids. Interviews with five caregivers confirmed there was adequate equipment.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All resident rooms in the rest home have direct access to a full ensuite - shower, toilet and hand basin. Hospital residents have communal facilities. Communal toilets have adequate signage. Visitor/staff toilets are well signed. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented.

##### **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:**

There is adequate space in all bedrooms for residents and staff. Five health care assistants were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Eight residents (three from the rest home, five from the hospital) are happy with their rooms.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The service has a main lounge and separate dining area. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout facility in wheel chairs and walking frames. Residents are able to move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements and give wheelchair access. Activities occur in the main lounge and residents are able to access their rooms for privacy when required. Residents interviewed are happy with the 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:**

There are cleaning policies and processes . Cleaning audits occur. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas with clear signs. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. The laundry are done on site;the area is clearly marked for clean and dirty laundry. Two laundry staff interviewed stated that they have a workable routine of sorting ,washing and drying of laundry. A service manual was sighted for all the laundry equipment.

##### **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:**

Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan (letter dated 10/07/2014). Fire evacuations are held six monthly and the last drill was completed 18 June 2014. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a generator, and a boor for water that is purified on site, and a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. Oxygen cylinders are available. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner. A test of a resident call bell demonstrated an appropriate response time.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

##### **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:**

General living areas and resident rooms are appropriately heated and ventilated. All bedrooms and communal areas have at least one external window. A record of monthly air temperatures are taken throughout the facility(sighted). Night lights situated at low level in all hallways.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint Minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within the service, d) use of enablers, e) enablers permitted, f) client rights, g) approval group, assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care chart, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) quality meetings, and p) maintenance. Related forms include: resident assessment summary, restraint consent, restraint safety and risk assessment, restraint monitor and review form, restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The education records sighted evidence of annual restraint and enabler education. The service philosophy around restraint is that it is used a last resort when all other interventions or calming/defusing strategies have not worked.

There is no documented evidence of a restraint approval group meeting at facility level as per policy (link 1.2.3); however the type and number of restraints are presented at the monthly quality meeting. The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler. There are 48 residents using restraint. This include bed rails, chair briefs,fall out chairs and the use of cocoons. The number of restraints were confirmed with the general manager and 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.)*

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three monthly and presented at the health & safety and infection control committee, then up to the quality meeting. There is no documented evidence of a restraint approval group at facility level as per policy; including the review of associated risks and alternative methods. Documents evidence approval from the restraint co-ordinator in consultation with family/ whanau but no input from other health professionals is evident - five files (hospital) reviewed for residents using restraint - and this is an area of improvement.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The policy identifies the responsibility and accountability of staff. There is evidence that the restraint coordinator in consultation with the family/whanau completes the approval of the restraint and enabler use, risk assessments and the three monthly evaluations.

**Finding:**

(i) Risk assessments are not completed consistently with other clinical assessments for example: one hospital resident last risk assessment was done in 2012; however, her cognitive ability has deteriorated since; ii) five files (hospital level) lack evidence that discussions of risks and restraint use happens on multidisciplinary level

**Corrective Action:**

Ensure a) restraint approval process is a multidisciplinary approach and evident in documentation; b) Risk assessments are consistently reviewed with other clinical assessments

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by the restraint coordinator with the resident and their family/whanau however, five (hospital) assessments were not reviewed in conjunction with the other clinical assessments (link 2.2.1). Assessments are completed at inception of restraint use for individual residents. The five files sampled identified that a restraint assessment, discussion with family/whanau and consent form were completed for the five residents requiring restraint and an enabler assessment and consent form is completed for the one resident requiring an enabler whose files were sampled.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service (link 2.2.1). There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. The restraint assessment identifies specific interventions or strategies to try (as appropriate) before using restraint. Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and its outcome that aligns with a) - g) in this criterion. Restraint monitoring forms include type of restraint used, risks associated with type of restraint, times restraint on/off, toileting, wheelchair lap belt use and repositioning of a resident when in bed. Forms include assessment, monitoring, risks, consent and alternatives to restraint. Six files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. Monitoring forms were completed. A three monthly evaluation of restraint and enablers was completed. The service has a restraint register and an enablers register that records sufficient information to provide an auditable record of restraint use.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The files reviewed of residents requiring restraint have been evaluated three monthly. Family/whanau participates in evaluations and at the residents' contract and care review meeting. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). Restraint practices are reviewed on a formal basis in the staff meetings and health & safety and infection control committee. A restraint evaluation is completed of the restraint care plan three monthly. Evaluation timeframes are determined by risk levels. Family/whanau is involved in review at residents' contract and care review meeting.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Approved restraint for each individual is reviewed at least three monthly by the restraint coordinator and as part of the annual contract and care review meeting with family/whanau involvement. Restraint usage across the facility is monitored monthly and advised that it is discussed at monthly staff and health & safety and infection control committee (and then on to the quality meetings). An annual quality review of restraint usage is complete by the general manager. An Internal audit for restraint usage was done in January 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator. There is an implemented infection control programme that is linked into the quality management system. The quality committee (that includes infection control and health and safety) is responsible for the development of the infection control programme and its review. The programme is reviewed annually – March 2014 the programme was reviewed by an external consultant (part of Healthcare Help), and the facility programme was seen to incorporate recommendations made into the local programme. The facility has access to GPs, local laboratory, the infection control and public health departments at the local DHB for advice. There are monthly health & safety/infection control meetings. Information from these meetings is passed on to the staff meetings (and up to the Board via monthly reporting/meetings).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control committee (which is part of the health & safety meeting) e is made up of a cross section of staff including the nurse manager and a registered nurse (infection control coordinator). The facility also has access to an infection control nurse specialist, public health and GP's.

##### **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:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator and the infection control (health & safety) committee.

##### **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:**

The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator has completed external IC training, and is working towards a certificate in infection prevention and control. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and ongoing. Training on infection control is included in as part of the biannual training schedule and incorporated into the compulsory ‘make it happen’ study days. Resident education is expected to occur as part of providing daily cares, in addition the service has developed a residents infection control handbook that provides clear appropriate information about hand hygiene and cross infection.

##### **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:**

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at both the infection control and integrated meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Hand hygiene audits are included in the audit schedule (last completed March). There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator reported a norovirus outbreak in 2013 that affected ten residents and two staff – appropriate notifications were seen to have been made. There was reportedly an outbreak in 2012 (affecting approximately 40 residents and 40 staff) and the infection control coordinator informed the service had significant learnings from this event that has supported management of subsequent infectious events.

##### **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.)*