# Dutch Village Trust

## Current Status: 15 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

The facility can provide care for up to 45 residents (for both rest home and hospital level care). During the audit there were 44 residents living at the facility including 10 residents at rest home level of care and 34 residents at hospital level of care. The general manager was responsible for the overall management of the facility with the clinical manager providing clinical oversight.

Service delivery was monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys.

The staffing policy was the foundation for workforce planning. The staffing levels were reviewed for anticipated workloads and acuity with rosters indicating that staffing reflected resident acuity and bed occupancy. There was at least one registered nurse in the service at all times.

The service has received a rating of continuous improvement for good practice.

Improvements are required to advance directives and to administration of medication.

## Audit Summary as at 15 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 15 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 15 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 15 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 15 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 15 September 2014

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

### Infection Prevention and Control as at 15 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 15 September 2014

### Consumer Rights

The staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and the complaint process is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed and informed consent policy and processes are implemented by the service. Staff ensure that residents are informed and have choices related to the care they receive.

The service has received a rating of continuous improvement for good practice.

An improvement is required to advance directives.

### Organisational Management

Ons Dorp Care Centre has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed by the clinical manager with input from the management team. Quality improvement occurs through review of incidents, accidents, complaints, implementation of an internal audit schedule and a health and safety programme.

There are comprehensive human resources policies with an orientation/induction and training programme implemented. There is a policy for determining staffing and skill mix for safe service delivery with 24-hour registered nursing in the facility.

The general manager has been with the service since 2010 and has a master’s qualification in leadership. The general manager is supported by the clinical manager who has extensive experience in aged care.

### Continuum of Service Delivery

The resident’s entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. All residents have appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff with current practising certificates. The registered nurses conduct the initial assessment using standardised risk assessment tools. An information pack is provided to the resident/families on admission. Admission agreements are signed on admission by the residents or their families. The potential residents are recorded.in the enquiry book. Declined residents are referred back to the referrer in a timely manner.

The service has an integrated system of documentation. The general practitioner (GP) admits new residents within 24-48 hours and conducts three monthly reviews or more as required. Resident lifestyle care plans are reviewed three monthly. Multi-disciplinary reviews are conducted annually.

Activities provided by the service are appropriate to the needs of the residents. The contents of the verbal hand-over between shifts are comprehensive. Progress notes are maintained and the levels of documentation by the staff reflect the care provided during the shifts.

Referrals are made to specialist medical services as well as other allied health professionals. There are policies and procedures for transition, exit, discharge or transfer of residents.

There are issues in relation to transcribing of medications and this requires an improvement. There are no expired or unwanted medications. There are two residents who self-administer medicines and a system is in place to ensure compliance of the residents. The self-administration policy and procedures is sighted.

A dietary requirement form is completed on admission. Modified diets are provided by the service. Food handling certificates are all current. The kitchen is managed by an independent catering service. The winter and summer menus are annually reviewed by a dietitian. Food temperatures and fridge/freezer/chiller temperatures are monitored daily. Staff are using clean technique in food preparation. The cleaning schedule is sighted and completed daily.

### Safe and Appropriate Environment

All building and plant complies with legislation with comprehensive fire safety checks by an external contractor. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is completed on site and the managers and staff monitor cleaning to ensure that the facility is clean at all times. Essential emergency and security systems are in place with regular fire drills completed.

One room that was an office has been converted to a bedroom and is able to take residents at hospital level care.

### Restraint Minimisation and Safe Practice

The restraint minimisation and safe practice policy and procedure are implemented by the service. The restraint register is current and there are four residents using restraint. There is no resident using an enabler. Restraint assessments, restraint consents and restraint monitoring forms are evidenced. Risk management plans are in place and three monthly evaluations are evidenced. Restraint minimisation and safe practice is encouraged. Staff demonstrate good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service trainings are completed annually and the restraint minimisation/safe practice policy and procedures are also reviewed annually.

### Infection Prevention and Control

The infection control programme is appropriate to the size and scope of the service and is reviewed annually. The service has adequate hand washing facilities. The infection control coordinator can access information within the service, from the DHB and through an infection control expert. The staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and infection control is part of the quality and risk meeting. In-service trainings are provided regularly for all staff. The service had an outbreak this year and this was resolved prior to this audit.

# 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:** | Dutch Village Trust |
| **Certificate name:** | Dutch Village Trust |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Ons Dorp Care Centre | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 15 September 2014 | **End date:** | 16 September 2014 |

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

One room that was previously an office has been converted to a bedroom and is able to take residents at hospital level care – confirmed during the audit.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 44 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 3.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 15.5 | Total audit hours | 39.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 19 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 60 | Number of relatives interviewed | 9 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 23 September 2014

## **Executive Summary of Audit**

**General Overview**

The facility can provide care for up to 45 residents (for both rest home and hospital level care). During the audit there were 44 residents living at the facility including 10 residents at rest home level of care and 34 residents at hospital level of care. The general manager was responsible for the overall management of the facility with the clinical manager providing clinical oversight.

Service delivery was monitored through a quality and risk management programme that included review of complaints, incidents and accidents, surveillance of infections, completion of internal audits, clinical indicator review and satisfaction surveys. The staffing policy was the foundation for workforce planning. The staffing levels were reviewed for anticipated workloads and acuity with rosters indicating that staffing reflected resident acuity and bed occupancy. There was at least one registered nurse in the service at all times.

The service has received a rating of continuous improvement for good practice.

Improvements are required to advance directives and to administration of medication.

**Outcome 1.1: Consumer Rights**

The staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and the complaint process is available to residents and their family. The residents' cultural, spiritual and individual values and beliefs are assessed and informed consent policy and processes are implemented by the service. Staff ensure that residents are informed and have choices related to the care they receive.

The service has received a rating of continuous improvement for good practice.

An improvement is required to advance directives.

**Outcome 1.2: Organisational Management**

Ons Dorp Care Centre has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed by the clinical manager with input from the management team. Quality improvement occurs through review of incidents, accidents, complaints, implementation of an internal audit schedule and a health and safety programme.

There are comprehensive human resources policies with an orientation/induction and training programme implemented. There is a policy for determining staffing and skill mix for safe service delivery with 24-hour registered nursing in the facility.

The general manager has been with the service since 2010 and has a master’s qualification in leadership. The general manager is supported by the clinical manager who has extensive experience in aged care.

**Outcome 1.3: Continuum of Service Delivery**

The resident’s entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. All residents have appropriate needs assessments. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff with current practising certificates. The registered nurses conduct the initial assessment using standardised risk assessment tools. An information pack is provided to the resident/families on admission. Admission agreements are signed on admission by the residents or their families. The potential residents are recorded.in the enquiry book. Declined residents are referred back to the referrer in a timely manner.  
  
The service has an integrated system of documentation. The general practitioner (GP) admits new residents within 24-48 hours and conducts three monthly reviews or more as required. Resident lifestyle care plans are reviewed three monthly. Multi-disciplinary reviews are conducted annually.

Activities provided by the service are appropriate to the needs of the residents. The contents of the verbal hand-over between shifts are comprehensive. Progress notes are maintained and the levels of documentation by the staff reflect the care provided during the shifts.   
  
Referrals are made to specialist medical services as well as other allied health professionals. There are policies and procedures for transition, exit, discharge or transfer of residents. Yellow envelopes are utilised.

There are issues in relation to transcribing of medications and this requires an improvement. There are no expired or unwanted medications. There are two residents who self-administer medicines and a system is in place to ensure compliance of the residents. The self-administration policy and procedures is sighted.  
  
A dietary requirement form is completed on admission. Modified diets are provided by the service. Food handling certificates are all current. The kitchen is managed by an independent catering service. The winter and summer menus are annually reviewed by a dietitian. Food temperatures and fridge/freezer/chiller temperatures are monitored daily. Staff are using clean technique in food preparation. The cleaning schedule is sighted and completed daily.

**Outcome 1.4: Safe and Appropriate Environment**

All building and plant complies with legislation with comprehensive fire safety checks by an external contractor. Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Laundry is completed on site and the managers and staff monitor cleaning to ensure that the facility is clean at all times. Essential emergency and security systems are in place with regular fire drills completed.

One room that was an office has been converted to a bedroom and is able to take residents at hospital level care.

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

The restraint minimisation and safe practice policy and procedure are implemented by the service. The restraint register is current and there are four residents on restraint. There is no resident using an enabler. Restraint assessments, restraint consents and restraint monitoring forms are evidenced. Risk management plans are in place for all four residents on restraint and three monthly evaluations are evidenced. Restraint minimisation and safe practice is encouraged. Staff demonstrate good knowledge about restraints and enablers. All staff have current restraint competencies. Restraint in-service trainings are completed annually and the restraint minimisation/safe practice policy and procedures are also reviewed annually.

**Outcome 3: Infection Prevention and Control**

The infection control programme is appropriate to the size and scope of the service and is reviewed annually. The service has adequate hand washing facilities. The infection control coordinator can access information within the service, from the DHB and through an infection control expert. The staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and infection control is part of the quality and risk meeting. In-service trainings are provided regularly for all staff. The service had an outbreak this year and this was resolved prior to this audit.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 2 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | If the resident is deemed not competent, then this is documented by the doctor. The form also includes preferences documented by family around resuscitation. The clinical manager describes actively engaging the family in the discussions. Some documented preferences written by family state that they do not want their family member resuscitated and this may be interpreted by staff as an advance directive. | Review documentation around advance directives to ensure that only residents deemed competent document this. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Staff working in the rest home are transcribing medications in six out of seven reviewed medication charts. Transcribed medications are written in the non-packed medication signing sheets which include analgesia, laxatives, anti-depressants, inhalers, ear drops, food supplements and creams.  Four out of four medication charts do not have documented instructions in relation to crushing of medications. | Staff must comply with current legislation and guidelines.  Medications charts must contain clear instructions in relation to crushing of medications in order to comply with current legislation and guidelines. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.8: Good Practice | Consumers receive services of an appropriate standard. | CI |  |
| HDS(C)S.2008 | Criterion 1.1.8.1 | The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation’s management team that includes the clinical manager, general manager, clinical team leader (CTL) with support from the gerontology nurse specialist and other specialists. A physiotherapist is available two days a week and as required to provide support. The general practitioner confirms that there is excellent clinical practice that includes timely assessments and referrals when required. The use of specialists to improve individual resident care is documented e.g. wound nurse specialists, speech language therapist (Waitemata District Health Board with weekly visits), gerontology nurse specialist, infection control nurse specialists, dietician (monthly visits and as requested), physiotherapist (two days a week), training through EBOS (suppliers of products) and others as required. The clinical manager describes getting the gerontology nurse specialist, professional nurse advisor and infection control nurse specialist to review policies or practice to ensure that these meet best and evidence based practice.  The annual quality and risk plan 2013-14 identifies key quality aims that cascade from the strategic plan/priorities. The aims include to provide safe and competent care, to reduce all avoidable harm, and to promote ageing in place and avoid admission to acute care services, to promote resident and family-directed care, and maximise residents pleasure and fulfilment of life goals. The following projects identify key improvements in services delivery. The quality and risk plan show documentation of reviews monthly and annual review against the plan.  There are groups developed to discuss medication safety, restraint minimisation, infection control, wound management and falls. The groups meet individually monthly and they either submit a progress report or attend the quality and risk meeting monthly. A key priority has been to decrease the number of falls, particularly falls with injury and on using data better to improve service delivery. The improvement specialist –First Do No Harm , Northern District Health Board Support Agency has been supporting the service through facilitation of workshops attended by a range of staff including registered nurse, enrolled nurse, clinical manager and caregivers around the ‘do no harm’. The regional consultant also provides practical support e.g. improvements to the incident and accident database which has allowed rapid analysis of data that is now used to download reports that has enabled improved knowledge of staff and improvements to service delivery. The clinical manager leads the huia group (linking to the ‘do no harm’ project) that includes meetings with six local rest home/ hospitals. This has led to improvements in standardisation of criteria around clinical outcomes, improvement in forms and templates used around falls prevention. Examples of the reports showing trend analysis using standardised definitions of clinical indicators.  The service has been actively engaged in the ‘do no harm’ project and has decreased the number of falls significantly as a result. Key areas developed have been a pictorial transfer plan and fall prevention strategies. There is a monthly report around pressure areas and falls and this is benchmarked through the District Health Board with organisations of similar size etc. The service is now completing a post falls analysis and the graphs reviewed around falls and injury as a result of falls indicate that from June 2013 to end June 2014 there has been a 50% reduction. The service has also reduced the injury rate to 0.05% and reduced the monthly average falls rate by 0.5%. The service is continuing to review the data monthly. The data is overseen by the clinical manager and fed back immediately when there is a preventative fall with staff able to put in additional strategies to improve practice within a day to a week depending on the level of need. This may also include extra training for staff (sighted on the training records with individual training given). The care plans reflect the individual strategies with these updated immediately as changes occur and incidents are analysed.  There is also a focus on improving practice around wound management. A wound resource pack is developed that links to foods for wound healing and the service has negotiated improvements in food quality to better support wound healing.. The number of wounds is documented through the quality and risk meetings and management of wounds is discussed through a ‘wound group’. The wound nurse specialist has been providing training for staff with two registered nurses identified as having additional District Health Board training that will lead to them being identified as the resource nurse for wound management. Referrals to a wound specialist are now faster and wound products are being used with greater effectiveness (measured through individual case review and documented). The service is now photographing and measuring wounds better and this has led to a greater ability to individualise strategies. A case study of one resident indicates that the improvements made to service delivery overall have led to healing of the wound (previously identified by medical specialists as not being able to be healed) and significant individual improvements in quality of life. The clinical nurse manager and the wound nurse specialist are discussing other ways to measure and monitor wound management.  The medication administration group is focusing on improving practice with significant improvements in training for staff and review of medications for individual residents. The competency assessment has been formalised with staff having increased knowledge around practice as demonstrated through the competency assessments. The improvements are being measured currently through the number of medication errors (decreased since June 2013 to current) by 20%. There is a formal process of consulting with the general practitioner to review current medication for any client who has a fall with harm or is deteriorating in state. This has led to a reduction in the number of drugs used by some residents with improved quality of life. Again, individual case reviews are documented that show improvements as a result of the strategies documented.  The clinical manager has links with the university to identify research opportunities for the service. Ons Dorp is one of six rest homes involved in the Aged Residential Care Healthcare Implementation Project (ARCHIP) Waitemata DHB and University of Auckland. This project aims to evaluate, improve and facilitate delivery of a WDHB wide intervention of the ARCHUS project (research targeting acute hospitalisations) aimed at improving care delivery and reducing avoidable acute hospitalisations. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, clinical team leader, registered nurse, enrolled nurse and six caregivers confirm their understanding of the Code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.

Training around the code of rights, privacy and confidentiality and complaints was last provided in September 2014.

The auditors noted respectful attitudes towards residents on the day of the audit.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

A registered nurse discusses the Code (may include the clinical manager or the clinical team leader), including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at times during the monthly residents' meetings (meeting minutes sighted).

Residents and family interviewed including eight residents (five rest home and three hospital) and nine family members (three rest home and six hospital) confirm their rights are being upheld by the service.

Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception and in a hallway close to another exit. Pamphlets around the Code are available at the front entrance of the service with posters in English and Maori in all areas. There are pamphlets available and in the information pack given at entry on the Code that have been translated into Dutch and Chinese as per resident need.

If necessary, staff will read and explain information to residents as stated by the caregivers and registered nurses interviewed. Information is also given to the next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Eight residents and nine family members interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process. All family members interviewed confirm that they know where to obtain complaints forms.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a philosophy that promotes dignity and respect, quality of life and a team approach to care. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code.

Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values with the registered nurse, clinical team leader and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed).

Interventions to support these are identified and evaluated. Residents are addressed by their preferred name and this is documented in seven of seven resident files reviewed (two rest home and five hospital).

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.

The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room with a number of rooms available for family and residents to meet. There is a large activities/dining/lounge area which can be used by any resident and family.

Three caregivers specifically asked report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents’ privacy is respected.

Caregivers interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available two days a week and as needed. Caregivers assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code as stated by the clinical manager, clinical team leader and staff interviewed. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect and last had annual training in September 2014.

Residents’ files reviewed (seven of seven) identify that cultural and /or spiritual values, individual preferences are identified as per individual needs. There are church services two times a week with some residents attending church with family.

There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

Residents and family interviewed confirm that personal dignity and respect is respected and there is no evidence of bullying from staff or of any abuse or neglect. All talk about the partnership approach used by the service that includes working together (staff, residents and family) so that any concerns can be discussed at any time and all can have input into the care and support required.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service implements the Maori health policies and plan with cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health policies.

The clinical manager has links to local kaumatua Maori services through the District Health Board with a kaumatua offering support when required.

There is one Maori resident living at the facility who is newly admitted. There are no special needs for the resident identified by staff at the moment as described by staff. There is one Maori staff member and the kaumatua who are able to provide support if required. Staff interviewed report specific cultural needs are identified in the residents’ care plans.

Staff are aware of the importance of family/whanau in the delivery of care for their Maori residents and staff interviewed can describe ways that they meet cultural needs.

Staff have had training around cultural safety and Maori health in September 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident is supported to be as independent as possible.

Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident’s cultural values and beliefs. This information is used to develop a care plan and includes input from the resident and their family (confirmed by residents and family members interviewed).

The service has one Dutch resident and one Asian resident who do not speak any English. There are four Dutch staff and two others who can understand the language. There are also residents in the village who can speak Dutch. The resident also has family involved. There is one staff member who can write mandarin and staff who can speak mandarin on site. The District Health Board interpreting services are stated as being available and examples are given by the clinical manager of the service using interpreters particularly for medical appointments.

Staff have had training around cultural safety in July 2013 and around Maori health in September 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The facility implements Ons Dorp Care Centre policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on eight of eight staff files reviewed.

The orientation and employee agreement provided to staff on induction includes standards of conduct.

Interviews with staff including the acting activities coordinator, the clinical manager and clinical team leader, registered nurse, enrolled nurse and six caregivers confirm their understanding of professional boundaries, including the boundaries of the caregiver’s role and responsibilities.

Family and visitors are encouraged to visit residents and nine relatives state that the service provides a welcoming and supportive environment.

##### **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:** CI

**Evidence:**

There are well documented and reviewed policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that that supports an internal audit programme.

There is a comprehensive training programme with records maintained. The staff interviewed including the six caregivers describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses, enrolled nurses, clinical manager, general manager and the clinical team leader.

Specialised training and related competencies are in place for the registered nursing staff and for caregivers.

There is a comprehensive programme of meetings and this ensures that the quality improvement and risk management programme is monitored with data used to improve service delivery. Projects are undertaken to improve the lives of residents with these evaluated to ensure that outcomes have improved.

All residents and families interviewed express a very high level of satisfaction with the care delivered with no residents or family identifying any opportunities for improvement. Family members interviewed describe care in the following way: ‘freedom to talk and offer suggestions’, ‘work as a team here’, ‘team effort and we feel we are part of the team’, ‘a high standard of care has remained since the last audit’, ‘excellent care’, ‘very happy’, ‘excellent communication’, ‘very happy’. The satisfaction surveys in November 2012 and April 2014 consistently indicate a very high level of satisfaction with 100% and 97% of respondents respectively stating that they are satisfied or very satisfied with care and support provided.

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation’s management team that includes the clinical manager, general manager, clinical team leader with support from the gerontology nurse specialist and other specialists. A physiotherapist is available two days a week and as required to provide support.

The clinical manager describes getting the gerontology nurse specialist to review policies or practice to ensure that these meet best and evidence based practice.

The service has been actively engaged in the ‘first do no harm’ project and has decreased the number of falls significantly as a result. The service has also made significant improvements in wound management and administration of medication that is currently being monitored.

The service has received a rating of continuous improvement for good practice which shows improvements in service delivery and quality of life for residents.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** CI

**Evidence:**

**Finding:**

The general practitioner reports a high standard of care is provided at the service and the registered nurses demonstrate good clinical assessment skills. Consultation is available through the organisation’s management team that includes the clinical manager, general manager, clinical team leader with support from the gerontology nurse specialist and other specialists. A physiotherapist is available two days a week and as required to provide support. The general practitioner confirms that there is excellent clinical practice that includes timely assessments and referrals when required. The use of specialists to improve individual resident care is documented e.g. wound nurse specialists, speech language therapist (Waitemata District Health Board with weekly visits), gerontology nurse specialist, infection control nurse specialists, dietician (monthly visits and as requested), physiotherapist (two days a week), training through EBOS (suppliers of products) and others as required. The clinical manager describes getting the gerontology nurse specialist, professional nurse advisor and infection control nurse specialist to review policies or practice to ensure that these meet best and evidence based practice.

The annual quality and risk plan 2013-14 identifies key quality aims that cascade from the strategic plan/priorities. The aims include to provide safe and competent care, to reduce all avoidable harm, and to promote ageing in place and avoid admission to acute care services, to promote resident and family-directed care, and maximise residents pleasure and fulfilment of life goals. The following projects identify key improvements in services delivery. The quality and risk plan show documentation of reviews monthly and annual review against the plan.

There are groups developed to discuss medication safety, restraint minimisation, infection control, wound management and falls. The groups meet individually monthly and they either submit a progress report or attend the quality and risk meeting monthly. A key priority has been to decrease the number of falls, particularly falls with injury and on using data better to improve service delivery. The improvement specialist –First Do No Harm , Northern District Health Board Support Agency has been supporting the service through facilitation of workshops attended by a range of staff including registered nurse, enrolled nurse, clinical manager and caregivers around the ‘do no harm’. The regional consultant also provides practical support e.g. improvements to the incident and accident database which has allowed rapid analysis of data that is now used to download reports that has enabled improved knowledge of staff and improvements to service delivery. The clinical manager leads the huia group (linking to the ‘do no harm’ project) that includes meetings with six local rest home/ hospitals. This has led to improvements in standardisation of criteria around clinical outcomes, improvement in forms and templates used around falls prevention. Examples of the reports showing trend analysis using standardised definitions of clinical indicators.

The service has been actively engaged in the ‘do no harm’ project and has decreased the number of falls significantly as a result. Key areas developed have been a pictorial transfer plan and fall prevention strategies. There is a monthly report around pressure areas and falls and this is benchmarked through the District Health Board with organisations of similar size etc. The service is now completing a post falls analysis and the graphs reviewed around falls and injury as a result of falls indicate that from June 2013 to end June 2014 there has been a 50% reduction. The service has also reduced the injury rate to 0.05% and reduced the monthly average falls rate by 0.5%. The service is continuing to review the data monthly. The data is overseen by the clinical manager and fed back immediately when there is a preventative fall with staff able to put in additional strategies to improve practice within a day to a week depending on the level of need. This may also include extra training for staff (sighted on the training records with individual training given). The care plans reflect the individual strategies with these updated immediately as changes occur and incidents are analysed.

There is also a focus on improving practice around wound management. A wound resource pack is developed that links to foods for wound healing and the service has negotiated improvements in food quality to better support wound healing.. The number of wounds is documented through the quality and risk meetings and management of wounds is discussed through a ‘wound group’. The wound nurse specialist has been providing training for staff with two registered nurses identified as having additional District Health Board training that will lead to them being identified as the resource nurse for wound management. Referrals to a wound specialist are now faster and wound products are being used with greater effectiveness (measured through individual case review and documented). The service is now photographing and measuring wounds better and this has led to a greater ability to individualise strategies. A case study of one resident indicates that the improvements made to service delivery overall have led to healing of the wound (previously identified by medical specialists as not being able to be healed) and significant individual improvements in quality of life. The clinical nurse manager and the wound nurse specialist are discussing other ways to measure and monitor wound management.

The medication administration group is focusing on improving practice with significant improvements in training for staff and review of medications for individual residents. The competency assessment has been formalised with staff having increased knowledge around practice as demonstrated through the competency assessments. The improvements are being measured currently through the number of medication errors (decreased since June 2013 to current) by 20%. There is a formal process of consulting with the general practitioner to review current medication for any client who has a fall with harm or is deteriorating in state. This has led to a reduction in the number of drugs used by some residents with improved quality of life. Again, individual case reviews are documented that show improvements as a result of the strategies documented.

The clinical manager has links with the university to identify research opportunities for the service. Ons Dorp is one of six rest homes involved in the Aged Residential Care Healthcare Implementation Project (ARCHIP) Waitemata DHB and University of Auckland. This project aims to evaluate, improve and facilitate delivery of a WDHB wide intervention of the ARCHUS project (research targeting acute hospitalisations) aimed at improving care delivery and reducing avoidable acute hospitalisations.

**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:**

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 20 of 20 completed accident/incident forms.

Family contact is recorded in residents’ files – sighted in seven of seven resident files reviewed (two rest home and five hospital) files reviewed.

Interviews with nine family members confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings.

Family interviewed confirm that they are invited to attend the monthly resident meetings but state that the managers encourage discussion and are easy to relate to. All state that if they have any concerns, they are able to be raised and resolved in a timely manner.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes a general consent e.g. for sharing of information, consent for care and treatment.   
Seven of seven admission agreements sighted have all been signed on the day of admission.   
Discussion with residents and relatives identify that the service actively involves them in decisions that affect their lives.  
  
There are advance directives documented. When the resident is deemed competent, then the resident documents advance directives as per their choice. The general practitioner documents if the resident is competent to make a decision around resuscitation. If the resident is competent, then this is recorded. If the resident is deemed not competent, then this is documented by the doctor. The form also includes preferences documented by family around resuscitation. The clinical manager describes actively engaging the family in the discussions. Some documented preferences written by family state that they do not want their family member resuscitated and this may be interpreted by staff as an advance directive.   
An improvement is required to documentation of advance directives.   
The District Health Board contract requirements are partially met.

Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes a general consent e.g. for sharing of information, consent for care and treatment.   
Seven of seven admission agreements sighted have all been signed on the day of admission.   
Discussion with residents and relatives identify that the service actively involves them in decisions that affect their lives.  
  
There are advance directives documented. When the resident is deemed competent, then the resident documents advance directives as per their choice. The general practitioner documents if the resident is competent to make a decision around resuscitation. If the resident is competent, then this is recorded. If the resident is deemed not competent, then this is documented by the doctor. The form also includes preferences documented by family around resuscitation. The clinical manager describes actively engaging the family in the discussions. Some documented preferences written by family state that they do not want their family member resuscitated and this may be interpreted by staff as an advance directive.   
An improvement is required to documentation of advance directives.   
The District Health Board contract requirements are partially met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are advance directives documented. The general practitioner documents if the resident is competent to make a decision around resuscitation. The clinical manager describes actively engaging the family in the discussions around advance directives.

**Finding:**

If the resident is deemed not competent, then this is documented by the doctor. The form also includes preferences documented by family around resuscitation. The clinical manager describes actively engaging the family in the discussions. Some documented preferences written by family state that they do not want their family member resuscitated and this may be interpreted by staff as an advance directive.

**Corrective Action:**

Review documentation around advance directives to ensure that only residents deemed competent document this.

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

Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.

Meeting minutes indicate that information is regularly provided to the residents regarding their right to access advocacy services through the training on the Code and advocacy services – last provided for staff in September 2014.

Discussion with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions and eight relatives state that they have been informed about advocacy services. The Code pamphlet is available in Chinese and Dutch and this references contact details for advocacy services.

The resident file includes information on resident’s family/whanau and chosen social networks.

Staff including the five caregivers interviewed are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings (earlier in winter to coincide with dusk) but visitors can arrange to visit after doors are locked.

Nine families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Family are seen coming and going freely on the days of the audit.

Residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services. The service activity programme includes performing groups who entertain residents. Residents are included in shopping visits and outings with families.

Communication with family members is recorded on incident forms (20 of 20 sighted), in communication forms on resident files and in progress notes.

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation’s complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint’s forms are available at the entrance.

A complaint register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder.

Three complaints documented in 2014 are reviewed. All are documented on the complaints register with all signed off stating that they are resolved. Letters to the complainant acknowledging the complaint and the resolution are sighted.

Eight residents (five rest home and three hospital) and nine family members (three rest home and six hospital) state that they would feel comfortable complaining. None had any complaint that they wished to follow up currently.

All resident admission agreements are signed on the day of admission (seven files reviewed).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Ons Dorp Care Centre has a management team including the general manager, clinical manager and clinical team leader providing support to the service.

There is a clear mission, values and goals – ‘quality of life through expert care’. The general manager also has a focus on maintaining ‘happiness’ through meeting stakeholder needs and on maintaining reputation.

The facility can provide care for up to 45 residents (for both rest home and hospital level care). During the audit there are 44 residents living at the facility including 10 residents at rest home level of care and 34 residents at hospital level of care. One room that was a storeroom has been converted to a bedroom that is able to take residents at hospital level care.

The general manager is responsible for the overall management of the facility and has a bachelor of science in industrial chemistry and a master’s in business leadership. The general manager has been in the role since 2010. The clinical care is overseen by the clinical manager who is a registered nurse (with current annual practicing certificate) with over 25 years’ experience in aged care including in the role as clinical manager.

There is a board that meets two monthly and reports are provided to the board from the clinical manager and the general manager against indicators including clinical, staffing and others. The business plan 2014-16 is reviewed at the board meeting (evidenced as being reviewed in the June 2014 meeting minutes).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

**Attainment and Risk:** FA

**Evidence:**

In the absence of the general manager, the clinical manager is in charge with support from the accountant around financial areas. The clinical manager is a registered nurse with over 25 years of experience in aged care.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a quality and risk management framework that is documented to guide practice. The annual quality and risk plan 2013-14 is documented with priorities, goals, actions, accountabilities and timeframes documented. The quality and risk plan is reviewed annually with data against the goals reviewed monthly.

There is a business plan documented 2014-16 and reported on through the monthly reports and discussed at the board meeting two monthly.   
  
The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. The clinical manager reviews all policies with input from the general manager and other staff. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy and electronically.   
  
Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with a corrective action plan documented and evidence of resolution of issues.   
  
All staff interviewed including six caregivers, the two activities coordinators, registered nurse, clinical manager and clinical team leader and general manager report they are kept informed of quality improvements through monthly meetings including quality and risk, staff, caregiver, resident, care centre meetings.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented with all hazards reviewed monthly. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

Monthly reports escalate any issues and inform the board of progress (two monthly board meetings). There are monthly meetings that have been held since mid-2013 around specific aspects of care i.e. falls management, medication administration and management of wounds. All aspects of the quality and risk management programme are discussed through the meetings with significant evidence that improvements are made as a result of data collected and analysed. Trends are analysed and graphs documented with these displayed in the staff room.   
  
The service is able to show quality improvements that are aimed at improving the lives of residents. Residents, family and the general practitioner interviewed confirm a high level of satisfaction with the service with this reflected in the meeting minutes, through interviews and through the internal audit programme. Corrective action plans are documented when issues are identified and there is a satisfaction survey one to two yearly. The results of the 2012 satisfaction survey show an overall satisfaction of 100% satisfied or very satisfied and in 2014 – 97% satisfied or very satisfied.   
  
The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

The general manager and clinical manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There has been an outbreak in January 2014 and relevant authorities are notified including public health and the District Health Board.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, clinical team manager and general manager.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Twenty incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.

Information gathered is regularly shared at the monthly quality and risk meetings with the clinical manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring.

All 20 incidents are signed off appropriately by the clinical manager and/or the clinical team manager

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All registered nurses, enrolled nurses, the clinical manager and the clinical team leader hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner, pharmacists, dietician, podiatrist and physiotherapists.   
  
Eight of eight staff files randomly selected for audit include appointment documentation on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in staff files and all staff have a first aid certificate (mandatory). Police checks are completed.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency and the staff interviewed state that they buddy any new staff member or bureau staff throughout the shift.

Caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and caregivers who administer medicines to residents.   
  
The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance as sighted on eight files of staff who had attended 2014 training. Attendance records are also retained. The six caregivers state that they value the training. Education and training hours exceed eight hours a year.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy (one to four staff to resident ratio implemented).

There are nine caregivers in the morning, seven in the afternoon and three overnight. There is a registered nurse on duty 24 hours a day with an extra registered nurse on duty three days a week and at other times on the morning and afternoon shifts to support documentation and support requirements. There is an enrolled nurse on duty in the morning and afternoon from Monday to Friday.

Residents and families interviewed confirm staffing is adequate to meet the residents’ needs.

There are currently 60 staff including the clinical manager, the general manager, clinical team leader, six registered nurses, two enrolled nurses, three activities staff, maintenance staff, household staff seven days a week, contracted physiotherapist for 7.5 hours a week (on two days a week)and 30 caregivers .

There is a registered nurse and the clinical manager on call within ten minutes of the facility.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.   
  
There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.  
  
Entries are legible, dates and signed by the relevant health care assistant, registered nurse or other staff member including designation.   
  
Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.  
  
Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.  
  
The District Health Board contract requirements are met.

##### **Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All residents have needs assessments completed by the DHB needs assessment service prior to admission to the service. The entry to the service policy is sighted. A welcome pack is also sighted which contains information about the service. The registered nurses (RNs) admit residents to the service using standard assessment tools.

All enquiries both telephone and walk-ins are evidenced in the enquiry register.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

When a resident’s entry to the service is declined, the resident is referred back to the referrer to ensure that the resident will be admitted to the appropriate level of care they are assessed. This is evidence in the declining entry to the service policy and as confirmed by the clinical team leader. There is documented policy on decline of entry to the service. Potential residents are also referred to nearby facilities when there are no available beds or when the service is not able to provide the required level of care of the resident.

##### **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:**

The residents receive timely, competent, and appropriate services that meet their assessed needs and desired outcome/goals. The registered nurses, physiotherapist, diversional therapist, general practitioner (GP) and pharmacists have current practising certificates sighted. The registered nurses (RNs) admit residents using standardised risk assessment tools and develop an initial plan of care. The physiotherapist conducts a thorough assessment on admission and develops a transfer plan and falls strategies for all residents as evidence in seven out of seven reviewed resident files. There is evidence that the GP admits residents within 24-48 hours of admission to the facility. Short term care plans are consistently developed when acute conditions are identified. The resident lifestyle care plans (RLCPs) in the seven reviewed residents’ files are reviewed every six months. The RLCP’s are resident-focused and customised to the need of the residents. The RNs document the date of resolution in the sighted short term care plans. Post fall assessments and falls audit are completed for all falls.

The contents of the witnessed afternoon hand over are comprehensive to ensure the continuity of care. The hand over also includes information about a new resident. The seven reviewed residents’ files reflect an integrated system where all staff, GP and other members of the allied health team write in specific areas in the residents’ files.

The District Health Board contract requirements are met.

Tracer Methodology 1: Rest home level of care

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

Tracer Methodology 2: Hospital level of care

*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:**

The resident’s needs, support requirements, and preferences are gathered and recorded in a timely manner. The RNs use standardised assessment tools on admission to establish the required level of support of the resident and as the basis for RNs in developing the initial plan of care and the resident lifestyle care plan (RLCP). This includes pain, falls risk, pressure sore, mini-nutritional, dietary, depression, skin, continence, cultural, activities of daily living and spiritual assessment.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident lifestyle care plans (RLCPs) in the seven reviewed resident’s files are resident-focused and have inputs from other members of the health team. The RLCPs are updated when the interventions are not effective as identified during regular assessments and reviews. The short term care plans are developed when a resident develops acute infections.

The service has an integrated system in documentation. The registered nurses (RN)s and caregivers document what happened during their shifts in one section while the GP and other members of the allied health team write in specific sections in the resident’s file.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The documented interventions in the seven reviewed residents’ files are sufficiently detailed and well-documented to address the assessed needs and desired outcomes. Interventions in managing other infections are documented in the progress notes, short term care plans and RLCP’s.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Activities provided by the service are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activities coordinator develops the yearly activity plans. The relieving activities coordinator reports that copies of the weekly activities are provided to all residents on a Sunday including the weekly meal menus at the back of the activity programme. The rest home and hospital residents have the same activity programme with the addition of one-on-one sessions provided for the hospital residents. The seven out of seven reviewed resident files have well-documented activity plans that reflect the resident’s preferred activities. The resident activities participation log is sighted.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The RN conducts six monthly evaluations and multidisciplinary care review of all seven out of seven reviewed resident files. The resident’s response to treatment is documented in the short term care plans and resolution of the acute infection is documented in the short term care plans.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are referred internally to other members of the allied health team like physiotherapist. The physiotherapist visits twice a week and ensures that urgent matters are addressed immediately especially when residents had falls or changes in mobility status. The physiotherapist also conducts regular group exercises as witnessed during the day of the audit as well as facilitating the daily walks program. The outside referrals are facilitated by the clinical team leader (CTL). The CTL refers residents to the speech language therapist and dietician when residents experience swallowing difficulties. A sample referral to the speech language therapist and dietitian is sighted in the resident’s files.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service uses a transfer document when residents are transferred to the public hospital or to another service. They also utilise the yellow envelope which is developed by the DHB when transferring resident to and from the public hospital. The resuscitation status, medication charts, latest three days of progress notes, medical notes and front covers of the care plans are the documents included in the yellow envelope. Families are involved with the transfers/exits and discharges of the residents. The CM provides verbal hand overs when transferring the residents to another service.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service has a medicine management system to ensure that the residents receive medicines in a safe and timely manner. There are issues in relation to transcribing medications and documented instructions in relation to crushed medications. These are areas for improvement in 1.3.12.6. The 14 out of 14 reviewed medication charts reflect three monthly reviews conducted by the GP. All discontinued medications are signed and dated by the GP. Allergies are well-documented in the medication charts. The RNs conduct medication reconciliation on admission of a new resident or when a resident is discharged from the hospital back to the service.

The two RNs in the witnessed medication rounds demonstrate compliance with the medication administration policies and procedures of the service. The RN uses the hand sanitizer in the medication trolley before and after administering medications. All staff who administer medications have current medication competencies as evidence in the file. The annual medication competency training in-service is last conducted on April 2014.

There no expired or unwanted medications sighted. Expired medications are returned to the pharmacy in a timely manner. The controlled drugs register is current and correct. The service conducts a weekly stocktake of the controlled drugs as sighted in the controlled drugs register.

There are two residents who self-administer medications. The self-administration policies and procedures are in place. The two residents confirm that the RNs provide adequate information regarding their medications.

The medicine fridge is monitored daily. There are sharp bins sighted in the two medication rooms.

The District Health Board contract requirement is not fully met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The GP conducts three monthly reviews of all 14 reviewed medication charts. There are photos and allergies sighted I all 14 reviewed medication charts. The GP signs all discontinued medications as sighted in all 14 medication charts. The service conducts weekly stocktake of controlled drugs. The two RNs follow the medication administration procedure. Medications are stored in the medication room and inside the medication trolley. The CTL reports that all expired, unwanted or discontinued medications are returned to the pharmacy in a timely manner. There are no expired medications sighted in the medication rooms. The CTL also mentions that they conduct medication reconciliation when a resident is admitted to the service and after discharge from the hospital.

**Finding:**

Staff working in the rest home are transcribing medications in six out of seven reviewed medication charts. Transcribed medications are written in the non-packed medication signing sheets which include analgesia, laxatives, anti-depressants, inhalers, ear drops, food supplements and creams.

Four out of four medication charts do not have documented instructions in relation to crushing of medications.

**Corrective Action:**

Staff must comply with current legislation and guidelines.

Medications charts must contain clear instructions in relation to crushing of medications in order to comply with current legislation and guidelines.

**Timeframe (days):** 90 *(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:**

The GP conducts three monthly reviews of all 14 reviewed medication charts. There are photos and allergies sighted I all 14 reviewed medication charts. The GP signs all discontinued medications as sighted in all 14 medication charts. The service conducts weekly stocktake of controlled drugs. The two RNs follow the medication administration procedure. Medications are stored in the medication room and inside the medication trolley. The CTL reports that all expired, unwanted or discontinued medications are returned to the pharmacy in a timely manner. There are no expired medications sighted in the medication rooms. The CTL also mentions that they conduct medication reconciliation when a resident is admitted to the service and after discharge from the hospital.

**Finding:**

Staff working in the rest home are transcribing medications in six out of seven reviewed medication charts. Transcribed medications are written in the non-packed medication signing sheets which include analgesia, laxatives, anti-depressants, inhalers, ear drops, food supplements and creams.

Four out of four medication charts do not have documented instructions in relation to crushing of medications.

**Corrective Action:**

Staff must comply with current legislation and guidelines.

Medications charts must contain clear instructions in relation to crushing of medications in order to comply with current legislation and guidelines.

Staff must comply with current legislation and guidelines.

Medications charts must contain clear instructions in relation to crushing of medications.

**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 kitchen is managed by an independent catering service for more than seven years. There are two chefs who run the kitchen. The catering service provides the residents with meals that meet their food, fluids and nutritional needs. The RN completes the dietary requirement form on admission and provides a copy to the kitchen. The chef updates the kitchen board regularly. The catering service also provides additional or modified foods depending on the need of the residents. This include puree, soft, mince/moist, dairy-free and gluten-free meals. Fridge and chiller temperatures are monitored daily. Food temperatures are monitored and recorded after cooking and before serving to the residents. The kitchen staff use clean technique in preparing meals for the residents. All prepared foods in the chillers like sandwiches are covered and dated. A kitchen cleaning schedule is sighted and completed daily. Cooked meals are transported to the dining areas and in the rooms via a bain marie.

The service conducts monthly weighing of residents or more frequent as required as evidence in the weight monitoring folder. Weights are stable as sighted. The meals are well presented as sighted during the observed lunch. All interviewed residents verbalise that they enjoy the food provided by the service.

The two chefs and two kitchen assistants working in the kitchen have current food handling certificates. The operations manager places orders directly to their suppliers. The catering operations manager and the chef report that they use the first in-first out system for all their food supplies.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available in the facility and accessible for staff. The hazard register is current and reviewed at least quarterly. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances, last conducted in March 2014, as part of infection control training.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas.

Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 23 November 2014). There have been no buildings modifications since the last audit however there are room refurbishments. There is a planned maintenance schedule implemented.

One room that was a storeroom has been converted to a bedroom and is able to take residents at hospital level care.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programmes two yearly and this is up to date having been completed and BV Medical have checked all medical equipment in September 2013.

Interviews with six caregivers, a registered nurse, the clinical team leader (CTL) and the clinical manager confirms there is adequate equipment and cupboards viewed indicate that there are plenty of supplies.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required. There are safe outside areas that are easy to access for residents and family members.

There are a number of checks of the facility through the internal audit programme.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/bathing facilities. This includes full ensuites in some rooms, shared ensuites in some rooms and access to communal toilet facilities and shower facilities for all others. There are visitors’ toilets and communal toilets conveniently located close to communal areas.

The communal toilet facilities have a system that indicates if it is engaged or vacant and the last of these is being put in place following repainting of the areas.   
Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Residents and family interviewed including eight residents (five rest home and three hospital) and nine family members (three rest home and six hospital) report that there are sufficient toilets and showers.

##### **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 personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all and three residents asked specifically if they were always supported by two staff when using a hoist confirmed that this occurred at all times.

Rooms can be personalized with furnishings, photos and other personal adornments.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required.

##### **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 lounge/dining areas including a large lounge and dining room. The space is well used for group and individual activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. There is a specific area for a hairdresser.

##### **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:**

Laundry is completed the site. There are washing machines and dryers. There are two sluice rooms and colour coded linen bags. The laundry staff member interviewed confirms knowledge of the process for management of laundry, as per the policy.

There are cleaners on duty seven days a week and the cleaners are observed to have the cleaning trolley in the room with them when cleaning and all have appropriately labelled containers. Cleaning is monitored through the internal audit process with no issues identified in audits completed in 2014. Chemicals and cleaning cupboards are locked on the day of the audit.

The caregivers interviewed state that they make sure that when new residents and/or clothing come in, that all are named to avoid clothes being lost.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An evacuation plan was approved by the New Zealand Fire Service in 18 March 2010.

An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with these being up to date in 2014. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures.

All staff members have a first aid certificate – sighted on files reviewed.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes by the external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. Back up emergency lighting is in place and this is fully checked.

The doors are locked in the evenings doors for security. Systems are in place to ensure the facility is secure and safe for the residents and staff including closed circuit television. External lighting is adequate for safety and security with sensor lights on the outside of the building.

An electronic call bell system is in place. The staff interviewed including the caregivers state that they remain aware of residents who require frequent checks or who require more checks because they are in the room when other residents are involved in communal activities. There are call bells in all residents’ rooms, residents’ toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell audits are routinely completed.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The service demonstrates that the use of restraint is actively minimised. There are currently four residents on restraint (two on lap belt, one on low bed with landing impact mat and one on bed rail). An updated restraint register is sighted. The restraint coordinator completes the restraint assessment and consent forms as evidence in the four reviewed resident’s files on restraint. There is no resident who uses an enabler.

The clinical team leader (CTL) is the designated restraint coordinator and the signed job description is evidenced in their staff file. The restraint coordinator reports that restraints are approved by the restraint approval committee restraint coordinator, GP and resident/family. There is a falls group formed to increase staff awareness and monitor falls and develop interventions to minimise/prevent falls. This group coordinates with the falls prevention group in the DHB. The restraint minimisation policies and procedures are sighted. The risk management plans are documented in the four resident’s care plan-restraint section. The resident’s families verbalise that the use of restraint is communicated to them by the restraint coordinator.

All staff has current restraint competency as sighted.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service demonstrates that the use of restraint is actively minimised. There are currently four residents on restraint. The restraint coordinator reports that restraints are approved by the restraint approval committee before commencing any restraint. This is sighted in the restraint assessment forms of all four residents on restraints. The risk management plans are documented in the four resident’s care plan-restraint section.

The District Health Board contract requirement is met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator completes a restraint assessment form prior to commencing any resident on restraint. This is evidenced in the four out of four reviewed residents’ files using lap belts, low a low bed and a bedrail. The risk factors are identified in the assessment as well as the resident’s current condition and why the restraint is necessary. There are risk management plans in place sighted for all four residents using restraints. The desired outcome is clearly documented and reported to the resident/family. Alternative interventions are also sighted prior commencing the residents on restraints.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The service provider use restraint safely. There are currently four residents on restraint. The restraint register is current and the care plan-restraint section have documented risk management plans. The caregivers complete the restraint monitoring forms every shift as sighted. All interviewed RNs and caregivers demonstrate excellent knowledge about restraints, enablers and are able to discuss risk management plans to prevent injury on the resident. The restraint minimisation policies and procedures are in place and accessible for all staff to read. The restraint coordinator reports that there are no restraint-related injuries reported. The low bed and the bedrail are included in the annual maintenance plan as reported by the clinical manager. This is evidence in the maintenance plan folder.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator reports that they had eight residents on restraints but are reduced to four residents after conducting a restraint review. The restraint coordinator evaluates all four restraints currently in use as evidenced in the documentation. The restraint coordinator, GP and the resident’s family sign the three monthly evaluation forms and consents as sighted. This also includes evaluating the effectiveness of the restraint in use and the risk management plans documented in the care plan-restraint section.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service demonstrates monitoring and quality review of the use of restraint. Restraint is included in the quality risk meeting together with health/safety and infection control. The quality and risk team is composing of the clinical manager, clinical team leader, village manager, one RN and representatives from the maintenance, housekeeping, and laundry and cleaning departments. The service conducts monthly quality risk meetings and minutes of the meetings are sighted.

The restraint minimisation in-service training is last conducted on September 2014.

The restraint minimisation/safe practice policies and procedures are reviewed annually. The restraint internal audit is conducted annually.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. One of the registered nurses is the infection control co-ordinator (ICC) and the job description is signed off as evidence in the file. The ICC is new to the role and attends the May 2014 infection control training conducted in the DHB. The ICC is also supported by the clinical team leader.

The facility has a clearly defined infection control programme that is last reviewed in August 2014. Infection control is part of quality and risk management meeting every month. The use of antibiotics is monitored and recorded infection log which includes the date the infection is identified, type, prescribed antibiotics, length prescribed and the date the infection is resolved. The infections rates are collated for benchmarking and the results are discussed in the quality and risk meetings as evidence in the minutes of the meetings.

Infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident’s families and relatives are encouraged not to visit when they are unwell. Hand sanitizers are in the main reception area as well as in all the corridors.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. One of the RNs leads the infection control committee. The members of the infection committee are two caregivers and a registered nurse. Hand washing signs are sighted around the facility to remind staff and the residents of the importance of hand washing. The service maintains regular in-service training for infection control including outbreak management, standard precautions, personal protective equipment, laundry care and hand washing. There are sufficient gloves in the corridors, sluice rooms and in the resident’s rooms.

The infection control coordinator accesses information through the DHB infection control prevention nurse specialist and independent infection control experts.

The District Health Board contract requirement is met.

##### **Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)**

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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. The service evidences implementation of the policies and procedures and best practice. Staff are noted to be wearing gloves and aprons during care and there are no staff walking in the corridors wearing gloves or aprons. All interviewed staff demonstrate excellent knowledge on infection control prevention including the importance of proper hand washing.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The service provides relevant education on infection control to all staff and residents. The infection control education is provided by either the infection control coordinator, the clinical team leader or by invited infection control resource speakers. All staff complete an annual infection control quiz as part of the annual infection control update. All staff have hand washing competencies as sighted. Infection control training is last conducted in July 2014. The infection control coordinator reports that they conduct in service training every six months. Staff are able to discuss the importance of proper hand washing and what to do in the event of an outbreak. Staff in the kitchen wear gloves and aprons when preparing meals.

Residents interviewed are also aware of the importance of hand washing and mentioned when hand washing is required.

The District Health Board contract requirement is met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The surveillance for infection rate is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control surveillance is appropriate to the size of the service. Infection rates are monthly monitored and collated by the infection control nurse with the guidance of the clinical manager including urinary tract infections, skin, wound, respiratory tract infections, gastro-intestinal tract infections and ears/ear infections. These infections are entered in the intranet system for benchmarking with other services within the organisation. Infection rates are discussed during the monthly quality meeting as sighted in the quality meeting folder. The interventions to reduce, manage and prevent the infections are discussed during monthly quality improvement meetings as evidence in the records.  
  
The results of the monthly infection surveillance are sighted in the intranet and in the monthly quality improvement meetings.

##### **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.)*