# Laama Holdings Limited

## Current Status: 25 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

Epsom South Rest Home is a 27 bed rest home located in Epsom Auckland. At audit there are 24 residents receiving care. Since the last audit the nurse manager has reduced the hours worked in the rest home, however remains on call. A new registered nurse has been employed and is working full time hours weekdays. The director is on site every day and is responsible for operational issues. A new activities coordinator has been recently employed. There have been no significant changes to the land or buildings.

At this audit there are no areas identified as requiring improvement. Quality improvement data is collected analysed and communicated to staff and residents. This is an area of continuous improvement.

## Audit Summary as at 25 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 25 September 2014

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

### Organisational Management as at 25 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 25 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 25 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 25 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 25 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 25 September 2014

### Consumer Rights

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs.

Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence is seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits every six months for staff education and attendance at residents' meetings. All staff interviewed are able to verbalise knowledge of residents' rights.

There is a complaints policy which details that residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

### Organisational Management

The director purchased Epsom South Rest Home in October 2009 and continues to actively work in the rest home. The director is supported by an experienced nurse manager who has worked in this facility for three years. The nurse manager (NM) is responsible for ensuring the care needs of the residents are being met. Another registered nurse (RN) has been recently employed. The Epsom South Rest Home business plan and quality and risk plan provide the framework for all services provided. The vision, mission and goals of the rest home are clearly documented. A number of goals for 2014 relate to facility refurbishment and replacement of equipment. The director is monitoring progress to achieving these goals.

The quality and risk programme includes complaints, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk/hazard identification and management. The quality and risk programme was developed by an external quality adviser (QA) and individualised to reflect Epsom South Rest Home’s needs. The results of quality and risk activities are discussed with staff regularly at the monthly staff meetings or sooner during shift handover where applicable. This is an area of continuous improvement. Corrective action plans are developed where required, implemented and monitored for effectiveness.

Residents are included in all aspects of service planning and delivery. This was verified with all residents interviewed.

Current accepted human resources processes are implemented. Interviews are conducted and reference checks obtained. Staff are provided with an employment contract and job description. Staff performance appraisals are undertaken at least annually. Where staff or contractors are required to have an annual practising certificate, these are monitored and all are current.

New staff complete an orientation programme. Staff participate in regular on-going education. Staffing numbers meets the requirements of the provider’s contract with Auckland District Health Board (ADHB).

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

### Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home level care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The NM and RN oversee the care and management of all residents, along with a team of caregivers. All residents are assessed on admission and assessment details are retained in the individual resident’s records.

The residents’ care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The resident and family are involved in the care planning and review. The general practitioner ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service.

The activities available are appropriate for residents requiring rest home level care. A part time activities coordinator oversees the activities programme and staff assist and undertake designated areas of the programme.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The NM and RN are responsible for all areas of medication management and work alongside a contracted pharmacy.

Food service is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the NM or RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

### Safe and Appropriate Environment

Epsom South Rest Home has 23 single occupancy rooms and two share twin occupancy rooms. The majority of residents’ rooms are located on the ground floor. Five residents’ rooms are located on a slightly lower floor. There are processes implemented to ensure residents who are living on the lower floor are independently mobile. There are sufficient toilets and showers for residents. A number of residents’ rooms have either a toilet or full bathroom ensuite.

The laundry is located in the basement and are accessible to staff only. The building has a current building warrant of fitness. Clinical equipment has evidence of current performance monitoring. Electrical equipment sighted has evidence of electrical safety checking. Over the last year some improvements have been made in the facility with some bathrooms refurbished. New lounge furniture has been purchased and a number of beds replaced.

There is an approved fire evacuation plan and staff are trained in emergency and fire evacuation procedures. There are adequate supplies and equipment available and designated for use in an emergency. All staff have a current first aid certificate.

Staff dispose of waste and hazardous substances in accordance with the organisation's policies. Chemicals are stored in a locked cupboard.

Residents interviewed confirm the building is appropriately clean, ventilated and warm. There is a separate dining room and lounge area on the ground floor and a smaller lounge area on the lower floor. External areas are accessible to residents and family members, including those requiring the use of mobility devices. Security cameras are in use. There is an outside designated smoking area.

### Restraint Minimisation and Safe Practice

The service has clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers are only used to prevent harm and promote independent mobilisation. There are established systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Staff training and competency assessment in safe use of restraint occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. The committee also conducts regular quality reviews of restraint activity to ensure compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training. There is one resident using restraint at present.

### Infection Prevention and Control

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the nurse manager who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Staff and residents are offered annual influenza vaccinations. There have been no reported outbreaks of infections at this facility since the director purchased the service.

# HealthCERT Aged Residential Care Audit Report (version 3.92)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Laama Holdings Limited |
| **Certificate name:** | Epsom South Rest Home |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification audit | | | |
| **Premises audited:** | Epsom South Rest Home | | | |
| **Services audited:** | 57 Pah Road Epsom, Auckland | | | |
| **Dates of audit:** | **Start date:** | 25 September 2014 | **End date:** | 26 September 2014 |

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

Nil

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 24 |

## **Audit Team**

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

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 20 | Total audit hours | 44 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 5 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 9 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 19 November 2014

## **Executive Summary of Audit**

**General Overview**

Epsom South Rest Home is a 27 bed rest home located in Epsom Auckland. At audit there are 24 residents receiving care. Since the last audit the nurse manager has reduced the hours worked in the rest home, however remains on call. A new registered nurse has been employed and is working full time hours weekdays. The director is on site every day and is responsible for operational issues. A new activities coordinator has been recently employed. There have been no significant changes to the land or buildings.

At this audit there are no areas identified as requiring improvement. Quality improvement data is collected analysed and communicated to staff and residents. This is an area of continuous improvement.

**Outcome 1.1: Consumer Rights**

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs.

Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence is seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits every six months for staff education and attendance at residents' meetings. All staff interviewed are able to verbalise knowledge of residents' rights.

There is a complaints policy which details that residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

**Outcome 1.2: Organisational Management**

The director purchased Epsom South Rest Home in October 2009 and continues to actively work in the rest home. The director is supported by an experienced nurse manager who has worked in this facility for three years. The nurse manager (NM) is responsible for ensuring the care needs of the residents are being met. Another registered nurse (RN) has been recently employed. The Epsom South Rest Home business plan and quality and risk plan provide the framework for all services provided. The vision, mission and goals of the rest home are clearly documented. A number of goals for 2014 relate to facility refurbishment and replacement of equipment. The director is monitoring progress to achieving these goals.

The quality and risk programme includes complaints, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk/hazard identification and management. The quality and risk programme was developed by an external quality adviser (QA) and individualised to reflect Epsom South Rest Home’s needs. The results of quality and risk activities are discussed with staff regularly at the monthly staff meetings or sooner during shift handover where applicable. This is an area of continuous improvement. Corrective action plans are developed where required, implemented and monitored for effectiveness.

Residents are included in all aspects of service planning and delivery. This was verified with all residents interviewed.

Current accepted human resources processes are implemented. Interviews are conducted and reference checks obtained. Staff are provided with an employment contract and job description. Staff performance appraisals are undertaken at least annually. Where staff or contractors are required to have an annual practising certificate, these are monitored and all are current.

New staff complete an orientation programme. Staff participate in regular on-going education. Staffing numbers meets the requirements of the provider’s contract with Auckland District Health Board (ADHB).

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

**Outcome 1.3: Continuum of Service Delivery**

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home level care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The nurse manager (NM) and registered nurse (RN) oversee the care and management of all residents, along with a team of caregivers. All residents are assessed on admission and assessment details are retained in the individual resident’s records.

The residents’ care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The resident and family are involved in the care planning and review. The general practitioner ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service.

The activities available are appropriate for residents requiring rest home level care. A part time activities coordinator oversees the activities programme and staff assist and undertake designated areas of the programme.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The NM and RN are responsible for all areas of medication management and work alongside a contracted pharmacy.

Food service is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the NM or RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

**Outcome 1.4: Safe and Appropriate Environment**

Epsom South Rest Home has 23 single occupancy rooms and two share twin occupancy rooms. The majority of residents’ rooms are located on the ground floor. Five residents’ rooms are located on a slightly lower floor. There are processes implemented to ensure residents who are living on the lower floor are independently mobile. There are sufficient toilets and showers for residents. A number of residents’ rooms have either a toilet or full bathroom ensuite.

The laundry is located in the basement and are accessible to staff only. The building has a current building warrant of fitness. Clinical equipment has evidence of current performance monitoring. Electrical equipment sighted has evidence of electrical safety checking. Over the last year some improvements have been made in the facility with some bathrooms refurbished. New lounge furniture has been purchased and a number of beds replaced.

There is an approved fire evacuation plan and staff are trained in emergency and fire evacuation procedures. There are adequate supplies and equipment available and designated for use in an emergency. All staff have a current first aid certificate.

Staff dispose of waste and hazardous substances in accordance with the organisation's policies. Chemicals are stored in a locked cupboard.

Residents interviewed confirm the building is appropriately clean, ventilated and warm. There is a separate dining room and lounge area on the ground floor and a smaller lounge area on the lower floor. External areas are accessible to residents and family members, including those requiring the use of mobility devices. Security cameras are in use. There is an outside designated smoking area.

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

The service has clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers are only used to prevent harm and promote independent mobilisation. There are established systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Staff training and competency assessment in safe use of restraint occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. The committee also conducts regular quality reviews of restraint activity to ensure compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training. There is one resident using restraint at present.

**Outcome 3: Infection Prevention and Control**

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the nurse manager who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Staff and residents are offered annual influenza vaccinations. There have been no reported outbreaks of infections at this facility since the director purchased the service.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

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

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The service demonstrates a continuous improvement focus for quality and risk activities. The NM has undertaken detailed analysis of fall related incidents and residents with infections. New interventions have been implemented to address falls and infections both at an organisation/systems level as well as for individual resident’s. Interventions are documented in residents’ care plans and in organisational corrective action plans. The infection and falls rates are communicated to staff and residents at meetings and via the noticeboards and new interventions implemented where required. There has been a 50% reduction in both infection rates and the incidents of falls between 2012 and 2014 (year to date). |

# 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:**

Five of the five staff interviewed and the registered nurse (RN) are able to demonstrate their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme (sighted). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the day of the audit all demonstrate knowledge of the Code when interacting with residents.

The six residents interviewed report that they are treated with respect and understand their rights. There were no relatives available on the day of the audit.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The client rights policy notes ‘It is our policy to ensure that resident’s rights are under no circumstances breached and that residents and caregivers understand the rights and the importance of them. To treat all Residents equal and with a strong sense of empathy, dignity and regard to individual rights needs and wishes without discriminating against race, religious or sexual beliefs’. The policy details that staff will be provided with training on the Code and that residents will be provided with information on entry to the service. The policy includes the contact details of independent advocacy services. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the NM). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education was held in September 2013 by the Nationwide Health and Disability Advocacy Service and is held annually.

The Nationwide Health and Disability Advocacy Services information is include in the Resident Information Pack given prior to or on admission to the service. Information about the Advocacy Service, including contact details, is available to residents and their families at the entrance to the facility (sighted).

Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with six of six rest home residents). ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The independence and individuality policy (July 2015) notes that Epsom South Rest Home philosophy has a high priority of maintaining the resident’s independence and encouraging individuality. Practical examples of how this is to occur including facilitating resident choice is included and includes spiritual values and beliefs. The sexuality and intimacy policy provides guidance for staff on resident rights and well as staff responsibility for the safety of residents. Guidance on managing inappropriate behaviour is included.

The privacy and dignity policy details how staff are to ensure the physical and auditory of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The process for accessing personal health information is detailed. The policy includes the principals detailed in the privacy act.

Evidence is seen in five of the five files reviewed of the residents' goals which are personalised and reviewed every six months. Two of the five files reviewed show evidence of goals which include maintaining independence physically by walking, which is a favourite pastime.

Five of five staff interviewed report knowledge of residents' rights and understand dignity and respect.

Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with six of six rest home residents).

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A template care plan (August 2011) is available for the identification and planning of care needs for Maori residents. The plan includes a range of cultural issues/considerations for staff to be aware of. The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. Family /next of kin input and involvement in service delivery/decision making is sought if applicable. Where required other supports are accessed. Best practice principals are identified. A commitment to the Treaty of Waitangi is included. The policy notes staff are to be provided with training on the provision of culturally appropriate care.

Maori residents with no one to advocate for them should be referred to a Maori support service.

The policy notes that Tangata Whanau will be consulted where necessary.

The NM reports on interview that there is one resident of Maori culture at present in the facility and the Tangata Whanau would be contacted when required. Education was given to staff on the Treaty of Waitangi in July 2013 and five staff interviewed report that they understand the Treaty of Waitangi and attend the education annually.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The cultural safety policy (July 2014) notes that care and services will be available to all persons assessed as requiring the level of residential care provided by this facility. All persons will have equal access to services and will not be discriminated against or prejudiced because of race, sex, creed, gender, religious beliefs, or other discriminatory factors. The manager and/or RN will determine the cultural and/or spiritual needs of the resident in consultation with the resident, family and significant others as part of the admission process. Specific health issues and food preferences are identified on admission. A management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident.

If required, a person acceptable to the resident shall be sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.

Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided (confirmed in interviews with six of six rest home residents) and review of satisfaction surveys.

Five of five staff interviewed report on the need to respect individual culture and values.

ARRC requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The good employer policy details that discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances. Discrimination is noted to be unlawful if it is based on one or more of the following grounds; sex, disability, marital status, age, religious belief, political opinion, ethical belief, employment status, colour, family status, race, and sexual orientation, ethnic or national origins.

The employment position descriptions define professional boundaries as part of employment contract. Five of five staff interviewed verbalise they would report any inappropriate behaviour to the NM. The NM reports they will action formal disciplinary procedure if there is an employee breach of conduct. There is no evidence of any behaviour that requires reporting and interviews with six residents indicate no concerns.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Evidence is seen of care staff undertaking or completed the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificate (sighted) and all staff who administer medication have yearly assessments to determine competency.

The registered nurse attends education sessions run by ADHB and has an up to date CV. The planned yearly education programme (operating and sighted), includes sessions that ensures an environment of good practice. The food service cooks have fulfilled the requirements of safe food handling.

Residents satisfaction surveys show evidence that they are satisfied with the meals and food supplied.

ARRC requirements have been met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

The cultural responsiveness policy notes interpreters will be accessed if required. Prior to admission of residents, who do not speak English, the senior staff member will offer the availability of the interpreting services to the resident and/or their family. These can be contacted via the DHB. The policy notes staff will only be used to interpret as a last resort, in an emergency situation, or for simple day to day communication.

The open disclosure policy (July 2014) details the resident’s right to open disclosure and how open disclosure is to occur.

Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with six of six staff and the NM). There is sufficient space in each single room to permit private discussions and a telephone is available for the resident's use.

Family members are used as interpreters, where appropriate, and with prior consent. If necessary, an interpreter within the community or staff is sought (confirmed in interview with the NM).

All ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resuscitation and consent policy details resident’s rights to have an advance directive. Only a competent resident can make an advance directive. Guidance is provided on medically initiated not for resuscitation orders and when these can be made. Residents are normally for resuscitation unless there is an advance directive or medical ‘not for resuscitation’ (NFR) instructions in place. Guidance is also provided in relation to living wills.

The policy also includes consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident’s right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney and ensuring where applicable this is activated. The informed consent policy (August 2014) provides further guidance on consent implication and processes when there are concerns about a resident’s competence. There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. The NM discusses information on informed consent with the resident and family/ whanau on admission. An advance directive enables a resident to choose if they would like active medical treatment to prolong life, transfer to base hospital for on-going treatment or comfort cares. The advance directive is filled out in consultation with the resident's doctor. The consent or non-consent to be revoked at any time. The five files reviewed have signed advance directive forms which meet legislative requirements

Family members and residents are actively involved and included in care decisions as evidenced in five of five residents' files reviewed.

All ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons (confirmed in interview with six residents).

Education from the Nationwide Health and Disability Advocacy Service was given in September 2013. The five staff interviewed report knowledge of residents’ rights.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents report on interview that they are supported to be able to remain in contact with the community by outings and the walks to local shops and parks.

There is portable phone which is taken to the residents as required.

Policy includes procedures to be undertaken to assist residents to access community services and a van is available.

Evidence in five of five files shows attendance at ADHB for appointments as required.

ARRC requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints management policy details residents will be informed of the complaints process on entry to service. The right of the resident or significant others to make a complaint is noted in policy. The complaints reporting, investigation and follow-up process is detailed along with timeframes. The policy complies with the requirements of the Code. A complaints register is required to be maintained.

Complaints forms are available in the dining area and can be accessed without request. There is a drop box outside the director’s office that complaints can be place in.

Six of six residents interviewed are aware of the complaints process and confirm they feel confident to raise issues with the NM or director.

The complaints register for 2014 is sighted. There are very few complaints reported. Four complaints selected and reviewed at random from the register confirms each complaint has been acknowledged, investigated and responded to within timeframes to meet the Code. The NM and director advise there have been no complaints to the District Health Board (DHB), Ministry of Health (MOH) or Health and Disability Commissioner (H&DC) since the last audit.

The three caregivers and the RN interviewed are able to describe their responsibilities when a resident makes a complaint. The NM is responsible for complaints follow-up. Complaints/concerns raised by residents at monthly meetings are also discussed with staff at the monthly meetings.

The aged related residential care (ARRC) 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:**

The business plan sighted is dated 8 October 2013. The quality and risk management plan details Epsom South Rest Home (ESRH) is a residential care facility for the elderly. The document includes (but is not limited to) the following areas: business strategy; marketing; and the management structure. The organisation has a business, quality and risk management plan. The organisation's quality improvement statement is noted. A mission statement and philosophy is identified. The mission statement is to provide a 'warm loving environment where care is individualised, flexible and genuine, where goals can be achieved and dreams realised through support, empathy and experience'. The organisation's philosophy includes assisting residents to maintain independence, is recovery focused, culturally sensitive, and encourage residents to be actively involved with decision making. There are documented nursing objectives and organisation goals and objectives. The nurse manager advises they reviewed this document on 5 July 2014 and the review is notated on the documents. The nurse manager and director (who is also the owner) confirm being involved with developing and reviewing the business plan. The nurse manager reports that monitoring of the organisation's performance also occurs via the internal audit process.

The NM advises communication with the director occurs verbally when on site and also via email or text message. Examples of frequent emails sighted demonstrates regular email communication is occurring on topics including (but not limited to): updates on individual residents changing care needs (including admission to hospital); required supplies/consumables; incidents and adverse events.

The NM and director advise the director is on site most days (including weekends). The director is responsible for developing the staff roster, payroll/accounts activities, ordering of supplies/consumables, and ensuring maintenance is undertaken as required (as advised during interview). The director also takes residents to appointments and outings as required with the exception of doctor’s appointments. The director also assists with service delivery as when required. The nurse manager confirms working with the director ensuring implementation of the quality and risk programme and ensuring the day to day care needs of residents are being met.

The nurse manager is a registered nurse who trained as a RN in the Philippines and has qualified as a registered nurse in New Zealand. The nurse manager (NM) holds a current practising certificate with an expiry of 30 June 2015 and this is sighted. The nurse manager is employed Tuesday and Thursdays between 3pm and 6pm and 7am to 3 pm on Saturday. The NM is also on call 24 hours a day and 7 days a week (24/7). This is noted on the roster. The three caregivers, director and RN interviewed confirm the NM is on call and is contactable when required. The nurse manager has worked in aged care facilities since November 2009 and has held the role of clinical manager and charge nurse in other facilities prior to employment at ESRH.

The nurse manager attends relevant ongoing education. The NM has recently completed a post graduate certificate in advanced nursing practice and leadership and management. A copy of the academic transcript is sighted.

The good employer policy notes the manager must hold a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities relevant to the sector. The role of the Manager includes, but is not limited to ensuring the residents are adequately cared for in respect of their everyday needs, and that services provided to residents are consistent with obligations under legislation and the terms of their Agreement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The director has owned the rest home since October 2009. The director previously worked for a multinational company for ten years in a variety of roles including as an accounting and systems support officer. The director is contactable via mobile phone at all times when not on site. The three caregivers, NM and the RN confirm the director is readily contactable ‘out of hours’.

In the NM absence the director is responsible for service delivery. A new RN has been employed and is being mentored by the NM. The NM remains on call 24/7 and provides advice and support as required.

ARRC 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 documented quality and risk plan which includes a quality policy statement and goals and objectives. Efficiency, effectiveness, safety, responsiveness and accessibility are identified as being essential to the quality and risk programme. The goals relate to consumer focus, certification/contractual requirements, staff education/training, human resource management, performance monitoring and risk management. A focus on continuous improvement is noted.

The quality folder includes a list of plans/aims and objectives for ESRH for 2014. This contains a list of 12 objectives for 2014 and includes some refurbishment/maintenance activities, and purchase of new resources/furniture. Seven of the aims/objectives are noted to have been achieved and signed off by the director between February and July 2014. Working towards meeting the other goals is in progress.

The health and safety policy (July 2014) details staff and management responsibilities in relation to the reporting, investigation, management and communication of hazards and accidents. This includes to eliminate, isolate and minimise hazards. Hazard registers are present for the kitchen, care service areas, cleaning/laundry, external environment, and the kitchen. The policy document includes template reporting forms and flowcharts to guide staff practices. New hazards are reported and mitigation strategies undertaken.

The risk management plan documents the organisation's risks and notes mitigation plans for each risk. The identified risks include clinical/care related risks, documentation risks, security events, incidents / accidents, infections, medication events, legislative compliance, natural disasters, loss of data. Staff competency, low occupancy, industrial action, risk to reputation and financial risk. The risk register is noted as being last reviewed on 7 July 2014 by the NM. The revised risk documentation has been discussed with the director as verified with the director during interview.

There is a control of documents and records policy. This document states the required features for document control. It lists the six manuals that comprise the quality manual system. All policies held in the manuals are reviewed annually by the external quality advisor. All required policies and procedures required to meet the ARRC contract are present. Changes to policies and procedures are emailed from the external advisor to the NM who then reviews the ESRH manual and makes any changes. The NM has personalised/localised policies to be reflective of the rest home. The manual review form present at the front of each folder is signed off by the NM and summarises both the changes made to individual policies and the overall reviews. As an example, the quality assurance folder was reviewed in January 2013. The NM advises staff are informed of changes to policies and procedures via staff meeting. This process is sighted to be implemented during audit. The obsolete policies have documentation across the entire page noting the policy has been updated and the old policy is folded in half. The NM demonstrated that the obsolete policies are filed in a separate folder and this is sighted.

A resident satisfaction survey was last completed in October 2013. This was reviewed during the last audit. A food specific resident satisfaction survey was conducted with 10 residents in September 2014. The results show and increased satisfaction with food services. More fruit is requested.

Residents meetings are held monthly. The director advises they do not attend this meeting to allow the residents to speak freely. The meetings are facilitated by the RN or NM or activities co-ordinator. A review of the meeting minutes for the period June 1014 to September 2014 (inclusive) identifies discussions are occurring on food service, staffing, the environment/facility, hand hygiene to reduce infection risks and the activities programme. The number of resident infections, falls and complaints are also discussed. The NM advises details of residents and specific events are not discussed, rather the overall numbers and themes.

Quality improvement data is collected analysed and communicated to staff and residents. The infection rate and falls rate have both reduced by 50% between 2012 and 2014 (year to date). This is an area of continuous improvement.

Corrective action plans are developed where areas for improvement are identified. The corrective action planning cycle is detailed and includes monitoring, assessment, action, evaluation and feedback. There is evidence that the corrective action plans are implemented and monitored for effectiveness.

Staff meetings are held monthly. The minutes of meetings held in July 2014, August 2014 and September 2014 demonstrates discussion has occurred on individual residents changing care needs, staff changes, environmental cleaning, infections, documentation, audit results, use of restraints, complaints/compliments, occupancy, the results of internal audits/surveys and reported events/incidents. A template is used for the recording of meetings minutes. Between eight and nine staff (including the NM and sometimes the director) attend each meeting. Three caregivers and the RN interviewed confirm they get timely feedback every month (or sooner where required via shift handovers) on quality and risk issues. The staff are able to identify the residents with restraints in use, the residents who are at risk of falling and those residents prone to infections.

ARRC 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:** CI

**Evidence:**

There is an organisation audit calendar which identifies the audits to be undertaken each month during 2014. All required audits have been noted on the calendar as having been completed and a summary of the results noted for quick reference. There are documented targets for compliance which are noted as quality indicators. Epsom South Rest Home has met or surpassed the quality indicators for all audits completed to date in 2014. A review of five audits selected at random: consent (February 2014); staff satisfaction (March 2014); infection control/hand hygiene (April 2014); clinical records (May 2014); and resident care (June 2014) identifies a high compliance with organisation policy/procedure or audit components.

**Finding:**

The service demonstrates a continuous improvement focus for quality and risk activities. The NM has undertaken detailed analysis of fall related incidents and residents with infections. New interventions have been implemented to address falls and infections both at an organisation/systems level as well as for individual resident’s. Interventions are documented in residents’ care plans and in organisational corrective action plans. The infection and falls rates are communicated to staff and residents at meetings and via the noticeboards and new interventions implemented where required. There has been a 50% reduction in both infection rates and the incidents of falls between 2012 and 2014 (year to date).

**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:**

There is an incident reporting policy dated May 2014. The policy notes an accident is anything that makes a resident unhealthy or unhappy; when personal injury occurs (ie, skin tears, infections, falls, fractures); and any incidence of abuse and/or neglect. An incident is where any event occurs which creates risk or potential harm or injury. Non conformities in products and services are also required to be reported. The responsibilities for staff and management in relation to the reporting, investigation and management of incidents and accidents is noted. The number and trends of incidents/accidents is to be collated on monthly basis. A template form is provided for reporting these events.

Four staff interviewed (three caregivers and the RN), and the NM are able to identify their responsibilities in relation to the reporting, investigating and management of incidents. Staff are able to provide examples of the type of events that are to be reported. Staff are responsible for completing incident forms and giving them to the NM or RN. Where a resident has been injured the nurse manager (NM) must be advised. The three caregivers and the RN interviewed confirm the NM is responsive to calls and comes and assesses residents if necessary.

All incident reports are reviewed by the NM. Six incident reports selected at random and reviewed related to falls, skin tear and medication events demonstrates that these incidents have been reported, investigated and corrective action plans implemented appropriately.

There are monthly incident summary reports sighted which detail the number of reported events via category (accident/injury, challenging behaviour, skin tears, falls and medication events). The time of day incidents occur are also noted. Resident care plans are reviewed and updated as a results or the review of the incident data. This is verified in a resident file sampled by the second auditor. Examples include the development of a specific plan developed to minimise falls late afternoon/early evening.

The number and types of incidents are communicated to care staff on at least a monthly basis via staff meeting and verified in meeting minutes sighted (refer to 1.2.3). The staff interviewed confirm that where events/incidents occur, these are documented in the resident’s notes and also handed over to the next shift during handover. A summary of events is also discussed at the resident meeting. The noticeboard in the dining room includes a summary of the significant progress made to reduced falls and infections. Refer to 1.2.3.6. The RN and the NM interviewed confirm relevant events are being reported in a timely manner. Applicable events have been reported in the five resident files sampled. The staff advise the residents family must also be informed when incidents occur.

The NM advises there have been no essential notifications since the last. The NM is able to identify that outbreaks, significant complaints, unexpected deaths of residents and serious harm events would be reported as an essential notification. The incident report policy includes the reporting requirements for serious harm events (as an external essential notification) and this document is sighted.

ARRC 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:**

Current annual practising certificates are on file for the NM, RN, GP, two podiatrists, five physiotherapists and two pharmacist’s. Copies of current New Zealand drivers licence are on file for the director, NM, RN and one caregiver. The activities coordinator does not drive residents.

Recruitment processes include staff completing an application form, conducting an interview, and reference checking. These are present in the staff file of the employees who have commenced work since 2012. Signed employment agreements and job descriptions are on file for the five staff whose file reviewed during audit.

Staff are required to complete an orientation programme which includes an orientation to the facility, policies and procedures, emergency management, security, fire safety, staff responsibilities, the Code, documentation requirements, and individual resident needs. The three caregivers and the RN during interview advise new employees are supernumerary and buddied with a senior caregiver or NM for several shifts. The staff confirms the orientation sufficiently prepares new staff for their role. Ongoing support is provided as required. Records evidencing staff are completing the requirements of the orientation programme sighted in all staff files sampled.

There is an education plan which details education required to meet the requirements of the HDSS Standards, ARRC contract and legislative requirements over a two year period. Records of attendance are kept and sighted includes (but is not limited to): infection prevention and control (January 2014); privacy/dignity and choice (April 2014); fire evacuation (May 2014); the aging process (June 2014); medication management (June 2014); complaints and the Code of rights (August 2014); wound care and pain management (August 2014); and quality and risk management (September 2014). Between six and eight staff and managers attend each session. All staff (including the NM and director) have a current first aid certificate and these are sighted.

The three caregivers interviewed confirm they have access to relevant ongoing education. The RN confirms being supported to attend relevant internal and external education.

ARRC 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 good employer policy notes there will be sufficient staff to meet the health and personal care needs of all Residents, at all times. There will be at least one staff member on duty at all times if there are less than 10 residents. There will be at least two staff members on (one on duty and one on call) if there are more than 10 residents but less than 29.The roles and responsibility of the RN are detailed. The manager, or delegated person, has discretion to extend hours and staff numbers to respond in certain situations i.e. special events, emergencies, resident acuity issues, outbreaks. The staffing level reflects: number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience. The DHB asked that the RN staffing levels/cover for services be reviewed during audit.

A review of the current roster and interview with three caregivers, the RN and NM confirms:

The NM is on site two afternoons a week between 3pm and 6 pm and between 7am to 3 pm on Saturday. The NM is on call when not on site. The director is also rostered on site every day for between three and five hours. The caregivers advise the director is very available and helps out as and when required. This includes taking residents on outings.

The activities coordinator is on site four days a week for dedicated hours. There are also dedicated hours for the cook seven days a week.

There is a minimum of one HCA on duty at all times and a manager on call. There is a second HCA on duty between 7 am and 7pm.

The three HCAs interviewed confirm the staffing is sufficient for their roles and responsibilities. The caregivers are responsible for cleaning and laundry activities and have task lists to share the responsibilities over all three shifts.

The six residents interviewed confirm staff are always accessible/available.

ARRC 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:**

There is evidence that consumer information is collected and stored in accordance with the NZ Health Records Standard. A consumer file is created prior to admission and essential information is entered on the day of admission (eg, medical conditions, medicines, next of kin and emergency contact numbers, initial assessments and the referral information). The front sheet of the record contains unique personal identifying information, such as the consumers NHI, date of birth, legal name, next of kin, past medical history, presenting medical and physical conditions, allergies/sensitivities, current GP, ethnicity, birthplace, current support needs levels and gender.

The current resident records (hard copy) are filed in the main staff office which is locked when not staffed as observed on days of audit. Information from the current files is ‘culled’ every three months and stored in a separate lockable office. Archived records of past or deceased residents are stored in a secure place on site.

The five residents’ records sampled demonstrate that entries are legible and the writer of each entry signs their initials and designation. Records are integrated with information from all disciplines, external providers and medico-legal information.

ARRC 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:**

An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the home. The NZACA standard Resident's Services Agreement is provided. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative.

The residents and family report the admission agreement is discussed with them prior to admission and all aspects are understood. All ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The NM reports that the needs assessment team at ADHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. There is a folder which contains documentation of all enquiries (sighted) and the action taken if the admission is declined. This includes contacting the referral agency.

##### **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:**

Policy identifies all assessment needs of residents are undertaken by competent and appropriate registered staff.

Service delivery documentation is overseen by the NM and the RN. Documentation is part of the audit process and reviewed at regular intervals to ensure it is completed within required timeframes. In the five files reviewed there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed in the required timeframes. The NM and RN have completed the inteRAI training and will be implementing the process later in the year. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed.

The NM reports there is a process for annual multidisciplinary resident review. There is evidence in the five files reviewed that the family/whanau are involved in all care changes and reviews. Handover at the beginning of each shift is undertaken in the nurses’ station. Epsom South Rest Home have the services of one contracted GP who visits weekly or at other times if required. There is a GP on call 24 hours a day and seven days a week (24/7) to cover for all residents.

The two caregivers and RN interviewed report that the Gerontology Nurse Specialist for the Older Person from the ADHB visit as required and a referral is made to a dietitian for unexplained weight loss.

The six residents interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed report that they are kept up to date with all clinical changes.

As reported on interview, the GP is satisfied with the care given to the residents. The GP is contacted regarding any concerns with residents and has a good working relationship with the staff.

Tracer Methodology Rest Home:

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

All ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and mental assessment. There are also assessment tools for post falls, alcohol related issues and challenging behaviours. Referral letters are sighted from external agencies, including ADHB clinics, and there is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all five files reviewed that assessments are conducted within the specified timeframes. In all five files reviewed, the assessment information is used as part of care plan development.

The NM reports that they oversee all care plans and residents and family are included.

All ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In all five files reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and mental capacity. Clinical risk tools are used as part of the intervention process and towards measuring achievement of desired outcomes.

All health professionals document in the resident's individual clinical file and have access to care plans and progress notes. Documentation in all five files reviewed include nursing notes, medical reviews and hospital correspondence. The residents report that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff report they are informed of any changes to care plans at changeover.

The RN accompanies the doctor on his rounds and the doctor documents the outcome in the resident’s notes. Evidence is also seen of letters from ADHB clinics. The care plan is written in a language that is user friendly and able to be understood by all staff. Care staff are told of any changes in the care plans at changeover of shifts. In all five residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau.

All ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the five files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and timeframes to ensure residents’ desired outcomes are being met. Evidence is seen in documentation of a resident whose falls risk assessment had changed from low to medium risk. Changes to the care plans included regular checking of the resident, leaving the resident’s bell accessible and a sensor mat would be used if required.

The five clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a part time activities coordinator employed at Epsom South Rest Home. Activities are available for all residents over seven days a week as the caregivers undertake activities during the hours when the activity staff are not on site.

The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activities coordinator reports that it is important to have activities at similar times as the residents appreciated the routine.

External visits for the residents include picnics, beach trips and van trips. The six residents report on interview that the activities are positive and include exercise and music. Favourite activities are reported to be the monthly theme events and entertainment.

The lifestyle care plan is completed and reviewed six monthly. Evidence is seen of three monthly resident meetings and annual resident satisfaction surveys.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident’s folder and each shift documentation is made in the file as required. These are transferred to progress notes when completed or transferred to the long term care plan.

Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the five files reviewed. Progress notes are signed each duty by caregivers and weekly by the RN. Evidence is seen of the family/whanau involvement in the care reviews. In all five files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. The six residents and three family members interviewed report that they are given the opportunity to be involved in all aspects of care and reviews.

The five clinical staff interviewed have knowledge of the care plan documentation requirements.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary. The family will be notified of the upcoming appointment and will be invited to attend and assist.

Five of five residents' files reviewed required referrals to other health services. Sighted in residents' files, is information relating to the referral process.

Residents are given a choice of GP when they are admitted. Most residents use the GP contracted to Epsom South Rest Home. If the need for other services are indicated or requested, the GP or NM sends a referral to seek specialist service provider assistance from the ADHB. The resident and the family are kept informed of the referral process.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There is a specific transfer form to document information involving the resident to the ADHB or other facility. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate. When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and observations. A verbal handover is given by the NM. Communication is maintained with the family at all times, as confirmed during interview of six of six residents.

There is open communication between the service and family/whanau in relation to all aspects of care, including exit, discharge or transfer.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The medication management policy provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. The process for disposing expired/unwanted medications is also noted. Residents have a right to refuse medications. Where a resident refuses medications must be documented and communicated. Errors are required to be reported via the incident reporting system. The management of controlled drugs is included and includes weekly checks of balance and six monthly quantity stock count. Residents who have been assessed as safe to self-administer medications (a template assessment form is available) are able to self-administer. The assessments are repeated on at least a three monthly basis. The policy notes the medical practitioner is to review all residents’ medications on the three monthly basis and document the review.

Non prescribed approved medications are listed for a limited range of medications that may be administered by the RN. The document notes the medication, frequency, dose and purpose.

Epsom South Rest Home uses the blister pack medicine system whereby medicines are delivered monthly except for ‘PRN’ (pro re nata) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are no controlled drugs on the premises and all processes comply with the legislative requirements.

There is evidence in all ten files reviewed that medication charts are reviewed three monthly by the GP or as required.

Standing orders are not used at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reports that the GP works with the pharmacy but is responsible for all medicines administered to residents. If medicine is brought in by family this is approved by the GP and the GP charts on the medication sheet.

The RN and competent caregiver are responsible for all medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines.

There is no self-administration of medicines at Epsom South Rest Home.

Medicine sheets are signed in ink as required following administration.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The food services manual (May 2014) identifies a food assessment is conducted when a resident is admitted to identify any dietary needs and food preferences. The policy details the principals of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements are also detailed. Guidance is provided on pureed diets, soft diets, diabetic diets, light diet, reducing diet and a normal diet. Portion sizes are includes as well as practices to ensure residents remain appropriately hydrated. Practices to clean the kitchen and associated equipment is included.

An individual dietary assessment is completed on admission which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans. Residents report they are satisfied with the food services and given choice of foods to cater for dislikes and preferences.

The service is managed by three cooks over seven days. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. All cooks are up to date with their food safety certificate. Evidence is seen of attendance at annual update education on infection control and first aid. The cook is supported by management with food supplies and the cook understands the individual requirements of the residents (as reported on interview with the cook).

The cook reports that at present all residents have a normal texture diet and there are no soft diets. Evidence is seen of diabetic diets, residents who are receiving supplements and residents who have food preferences.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policies, the medication management policy and the health and safety policies detail how hazardous substances are to be stored. The disposal processes for various categories of waste including sharps, used incontinence products, general waste, and unwanted/expired medication is also detailed.

Waste that may be contaminated or soiled with body fluid is double bagged in general waste bags. Other waste that is not controlled or hazardous (i.e. general waste, household recyclable) is discarded through the normal rubbish collection and recycle process. Used sharps are disposed of in a designated sharps container.

There is adequate supplies of personal protective equipment present at audit, including gloves, masks, aprons and eye protection. Staff are observed to be wearing personal protective equipment (PPE) appropriately during audit. Hats are worn by all staff entering the kitchen. A caregiver interviewed can identify when PPE is required to be worn.

Material safety sheets are available on site for cleaning chemicals and these are sighted. Chemicals are stored in manufacturer original labelled bottles and in a locked room.

ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a building warrant of fitness with an expiry date of 29 September 2014. The ongoing checks to maintain the building warrant of fitness are being undertaken and records are sighted. The responsibility for these checks have been contracted out to an external company.

Biomedical equipment has evidence of performance monitoring and this is last done in September 2014. This includes a tympanic thermometer, pulse oximeters, sitting scales and electronic blood pressure machine. Electrical safety test and tagging has been undertaken. Test and tag labels sighted on appliances confirm checking last complete on 22 September 2014.

The transportation of resident policy details the ESRH responsibilities to ensure residents transported are done so in a safe manner. The code of conduct for the driver is noted along with requirements to ensure the vehicle is maintained to meet all legislative and operational requirements. The rest home vehicle has a current warrant of fitness, registration and first aid kit and these are sighted.

Hot water temperatures of four resident rooms selected on a rotating basis are being monitored each month. The records sighted demonstrate all recorded temperatures are under 40 degrees Celsius. A plumber has recently reset the tempering valves to 45 degrees C. At audit a check of the temperature in one of the residents' room hand basins confirms the hot water is within required parameters.

There are handrails present in the corridors and stairwell up to the first floor. Grab bars are present in the toilet and shower areas (sighted). The floor surfaces are flat or have a visible gradient. Two residents are sighted mobilising using a mobility device independently. The director has documented a number of goals/objectives in relation to maintaining the environment and replacing furniture in the 2014 quality plan sighted. These are progressively being undertaken and includes replacing some of the lounge furniture, repairing a leak, refurbishment of a bathroom and establishing a vegetable garden.

There is a veranda which wraps around three sides of the rest home. Outside furniture available. Eight residents have rooms with ranch sliders which enable direct access to the deck. There is a designated smoking area for residents only.

##### **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 three toilets and four toilets/showers for all residents to use which are located throughout the rest home. These are accessible by all residents. There are six resident rooms which have a toilet ensuites (shared between two rooms). Four residents’ rooms have a full ensuite shared between two bedrooms.

There are signs used to identify when the bathroom or toilet is occupied or vacant. Privacy locks are fitted. Six of six residents interviewed are happy their privacy is maintained while using these facilities.

There are hand washing facilities in each resident’s room.

##### **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:**

All residents have single occupancy rooms with the exception of two bedrooms which are share twin. One share twin room is in use occupied by two residents. One other room is only occupied by one resident. There is a privacy curtain placed.

Each bedroom is personalised with residents’ personal property and has space for residents to mobilise independently or with assistance including while using mobility devices. Two residents are sighted mobilising in their room using a mobility aid. All six residents interviewed confirm there are no problems with access or space.

A caregiver interviewed confirms the residents' rooms are big enough for residents and staff to be in together including when residents require staff or family assistance or supervision.

##### **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:**

All residents have single occupancy rooms with the exception of two share twin rooms. One of these share twin rooms is occupied by two residents at audit (sighted). There is a lounge on the ground floor which is also used for the activities programme. There is a small lounge on the lower floor (split level) for use by residents who have rooms on this floor.

There is a separate dining room which has enough tables and chairs for all residents to be present at meal times. There is a chair in the hallway that can be used by residents who want to rest while mobilising to their room. There is adequate space available to meet resident’s needs as confirmed at interview with six of six residents.

##### **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:**

The cleaning policy (May 2014) details what cleaning is to be undertaken, the frequency and what products are to be used. The laundry policy details linen handling and washing processes (including temperature and chemicals used) for various linen including residents own laundry/clothes and soiled linen.

Monitoring the cleaning and laundry services is undertaken via the internal audit programme and as a component of the resident satisfaction survey. A cleaning audit was last undertaken in October 2013. Handling of delicate linen is one of three areas requiring improvement. The resident and family satisfaction survey in October 2013 included questions on cleaning and laundry services. Some changes were requested. The director has purchased new linen and towels, has moved to fleece blankets (rather than duvets) and changes have been made to the bathroom cleaning processes.

The six residents interviewed confirm the facility is kept clean and tidy. Personal laundry is washed and returned promptly (the next day).

Chemicals are stored securely in a locked cupboard.

##### **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:**

There is a flip chart available for staff to guide responses in an emergency. This includes bomb threat, robbery/hold up, admissions/transfers/deaths, challenging behaviour, poisoning, earthquake, volcanic eruption, water leakage and fire. This is dated as issued in June 2012. Staff completed an emergency response questionnaire in January 2014 detailing how they would respond to various emergency events.

There is a fire evacuation plan which was approved by the New Zealand Fire Service on 29 June 2006 and confirmation email sighted. A fire evacuation drill last occurred on 19 April 2014 and records are sighted.

There are four security cameras monitoring internal areas (kitchen, corridor, lounge and the laundry). The cameras display onto the nurse managers computer. Footage is reported to be archived for seven days before being automatically recorded over. There is a key pad entrance to the front door. The code is noted on the keypad. Six residents interviewed are able to demonstrate they can independently open the door without staff assistance. Visitors are given their own access code. The caregivers advise they manually lock the doors in the evening. All visitors after this time have to ring the doorbell and be given entrance by staff. The health and safety policy advises staff are required to check all residents are accounted for when the external doors are locked. External doors are to be locked no later than 8.30 pm and earlier when it gets dark earlier. The three caregivers interviewed detail the night security and checking process. ‘Comfort rounds’ are undertaken regularly at least three to four times a night. Some residents are checked more frequently.

There are call bells present at each beds pace and bathroom area. The calls bells have an audible sound when activated and the room/area is identified on a central wall panel to staff. Most of the resident rooms also have a light to illuminates on the ceiling outside the room. Two call bells tested at random during audit worked appropriately.

There is adequate supplies available in the event of emergency. This includes (but is not limited to): batteries, torches, medications, continence products, pandemic supplies, candles, duvet/blanket, gas BBQ and bottle, and water. There is sufficient dry food to last a week.

ARRC 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:**

All residents' bedrooms have a window of natural proportions which opens. Six of six residents and two of two members interviewed verify the facility is kept warm and well ventilated. There are electric wall mounted heaters or oil heaters in the residents' bedrooms and in the corridors (sighted). Additional heating was placed in the lower lounge during winter at the request of a resident.

On the two days of audit residents' bedroom windows are open plus some of the external doors as it is a warm spring day.

The smoking policy notes residents are only allowed to smoke outside in a dedicated area (outside under cover on the veranda). Staff and visitors are not allowed to smoke onsite. The director advised consideration is given to ensuring the smoke does not drift into other resident areas.

ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Document review: the restraint minimisation policy identifies:

- Epsom South Rest Home promotes a restraint-free environment

- A restraint coordinator is delegated the role with relevant authorities and responsibilities.

- An approval group is established headed by the restraint coordinator, this group meet annually, or as required, to review restraints, training and policy. The meeting is minuted and outcomes feedback to staff meeting

- restraint usage is kept to an absolute minimum

- restraint decisions are always in collaboration with a Doctor. The consent process is detailed.

- written clinical justification is required for the administration of any restraint. It must only be done after de-escalation and an alternative has been attempted and found to be inadequate. Consideration is given on any cultural needs the resident may have.

- the policy is reviewed bi-annually (or when legislation changes) by the approval group.

- all staff are trained/educated re the restraint policy and procedures, de-escalation techniques and managing challenging behaviours. This training is ongoing and training has been approved by the Approval Group and reflects the restraint/enablers approved in this facility.

The policy includes the definitions of restraint and enablers which aligns with the requirements of the standards; the monitoring requirements for residents when challenging behaviours is exhibited and in the event restraints are in use; the restraint reporting and evaluation process and maintaining the restraint register.

There is one resident using restraint at Epsom South Rest Home.

##### **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:**

At the time of audit there is one resident requiring restraint. All documentation, including assessment, approval processes and actions to be taken, are clearly set out should restraint be required. Policy shows that enablers are voluntary and that the least restrictive option would be used with the intention of promoting or maintaining resident independence and safety, such as a chair lap belt to prevent falls, or bedside rails to help the resident feel safe. Observation and staff interviews confirm that no restraint or enablers are in use at the time of audit. The RN and two caregivers interviewed demonstrate knowledge that enablers use is voluntary and the least restrictive option for the resident.

The ARCC requirements are 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:**

At the time of audit the documentation review of the resident using restraint showed evidence of assessment which compies with all criteria. There is evidence of monitoring and reviews with the multidisciplinary team to ensure review of alternative strategies . It is clear from the evidence that restraint is the last intervention and is used for resident safety.

The DHB contract requirements are 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:**

Epsom South Rest Home has a key pin to open the front door. All residents except four have their own pin number and evidence is seen of residents freely accessing this process. The four residents who do not have their own pin number are supported by staff to open the door. All five files have evidence of a consent form signed by the resident and family relating to the key pin door.

##### **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:**

Documentation evidence sighted relating to the monitoring of bedrails use as restraint . The staff report on interview that thy discuss restraint at staff meetings and any issues.

Consent forms are sighted and family involvement.

##### **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:**

As part of the quality process restraint is discussed and evidence is sighted of six monthly review. Staff report at interview that staff meetings are the forum for discussing al quality reviews and restraint is part of the agenda. Evidence is seen on the education plan of updates on restraint and challenging behaviour.

The NM reports that restraint monitoring is part of the annual review process .

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy (July 2014) notes Epsom South Rest Home will:

- adopt and implement policies/protocols/guidelines which are both practical and acceptable with the prime intention of reducing the risk of infection both to residents and staff.

- providing an advisory and educational service on infection control practices to staff, residents, and visitors,

- participate in monitoring of significant infections and adherence to policies and assessing environmental risks.

- seek education to stay up to date with current safe practices.

- provide new staff with relevant information during induction/orientation ensuring that they are aware of infection control principles in this facility.

- seek advice from GP and laboratory services in the event of an outbreak. The RN is responsible to for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.

Evidence is seen in documentation reviewed that the policy is integrated into all aspects of the infection prevention service.

The role of the infection control coordinator role and the responsibilities is identified in the infection control manual. This has been signed by the NM accepting the requirements. The NM is responsible for facilitating the infection prevention and control programme. However, all staff are included in the infection prevention and control team. The staff and managers interviewed confirm timely ongoing communication is occurring when residents are suspected or confirmed as having an infection. This includes shift handovers and discussion at monthly staff meetings. The NM advises there are no residents with a multi-drug resistant organism.

The policy notes staff and residents are offered annual influenza vaccinations. Five staff and fifteen residents have been documented as having influenza vaccination in March 2014. Personal protective equipment and water less hand gel is readily available and sighted to be used.

An annual review of progress to achieving the infection prevention and control objectives has been undertaken by the NM in May 2014. All 12 objectives are noted to have been met or exceeded.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The NM confirms being responsible for facilitating infection prevention and control activities. The NM has attended relevant education on infection prevention and control. This includes a study day provided by an external infection prevention and control consultant on 17 September 2013 and certificate of attendance sighted. The NM advises they liaise with the GP if there are any concerns about a resident with a known or suspected infection.

The NM is responsible for gaining infection control, infectious disease and microbiological advice and support, where this is not available within the organisation. The NM advises in the event of an outbreak advice will be sought from GP, gerontology nurse specialist at the DHB or Laboratory services. This advice has not been required to date.

The ARRC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control manual contains the policies and procedures required to meet this standard. The policies are appropriate to the service setting and are dated as reviewed in July 2014.

A copy of the infection prevention and control policies are available for staff to read/refer to as and when required and this is sighted. A caregivers interviewed confirm access to policies on infection prevention and control. Should they have any concerns they would contact the NM who is on call when not on site. The GP confirmed during telephone interview he is contacted by staff in a timely manner when the needs of the resident have changed.

##### **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:**

Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. Two in-service education sessions have occurred in 2014 on infection prevention and control topics. This included outbreak management/norovirus in September 2014 which was attended by eight staff and managers and the in-service in January 2014 was attended by six staff. In addition newsletters issued by the ARRC support service at ADHB include infection prevention and control topics. As an example during audit the newsletter received was on urinary tract infections. This information is disseminated to staff.

Residents and family are provided with advice on infection prevention and control activities via resident meetings. The resident meeting minutes includes discussion on the importance of hand hygiene and the overall number of resident infections to promote resident awareness.

Refer to 1.2.7 for information on the training undertaken by the RN on infection prevention and control topics.

The ARRC contract requirements are 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 infection control programme includes surveillance for the following types of infection:

- urinary tract infections

- respiratory tract infections

- skin infections

-conjunctivitis

- ear infections

- gastroenteritis

The programme includes documented definitions of infections (sighted). The surveillance method is also defined and suspected infections are to be reported on a template form. There is to be monthly analysis of infections.

Surveillance for residents with infections is occurring. Three of three caregivers interviewed advise they are responsible for advising the RN or NM if they are concerned a resident has an infection. The staff are able to identify the common signs and symptoms of infections.

A review of the infection surveillance data for 2013 and January 2014 identifies there has been a significant reduction in infection rates. A report sighted analysing the infection surveillance data for 2012 to date includes evaluation of the likely contributing factors and actions undertaken to reduce infections. This includes encouragement of residents and staff to use the waterless hand gel and offering additional fluids. There is a water cooler that residents can independently obtain a drink from. In addition staff offer residents additional beverage during the day and water is also provided in addition to hot drinks at lunch time. A copy of the infection analysis and recommendations is displayed for staff, residents and family on the dining room noticeboard (refer also to criterion 1.2.3.6).

A review of the applicable residents’ notes verifies short term care plans are developed as required for residents with infections. The residents’ files reviewed by the second auditor verifies infections are being appropriately reported. Laboratory results when received are signed off to verify they have been reviewed prior to filing.

##### **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.)*