# Tamahere Eventide Home Trust

## Current Status: 29 October 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance 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

There has been a significant change in the organisational structure of Tamahere Eventide Rest Home and Village since the previous certification audit. Rapid growth in the development of the retirement village and its services has resulted in roles and responsibilities being allocated to two new general managers who report to the chief executive. One general manager is responsible for care services being delivered to residents and the other is responsible for the retirement village and support services such as hospitality, building and grounds.

During this period of growth and change there have been three anonymous complaints to the office of the Health and Disability Commissioner related to resident falls and wandering. Two of these complaints have been investigated by specialist staff from Waikato District Health Board and the service has implemented a number of corrective actions aimed at reducing falls.

On the day of this unannounced surveillance audit there were 78 residents on site.

## Audit Summary as at 29 October 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 29 October 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 29 October 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 29 October 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 29 October 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 29 October 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 29 October 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. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Tamahere Eventide Home Trust |
| **Certificate name:** | Tamahere Eventide Home Trust |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Tamahere Eventide Home & Village |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 29 October 2014 | **End date:** | 29 October 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 78 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 10 | Total audit hours | 26 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 11 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 80 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXXXXX, 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 DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Tuesday, 18 November 2014

## **Executive Summary of Audit**

**General Overview**

There has been a significant change in the organisational structure of Tamahere Eventide Rest Home and Village since the previous certification audit. Rapid growth in the development of the retirement village and its services has resulted in roles and responsibilities being allocated to two new general managers who report to the chief executive. One general manager is responsible for care services being delivered to residents and the other is responsible for the retirement village and support services such as hospitality, building and grounds.

During this period of growth and change there have been three anonymous complaints to the office of the Health and Disability Commissioner related to resident falls and wandering. Two of these complaints have been investigated by specialist staff from Waikato District Health Board and the service has implemented a number of corrective actions aimed at reducing falls.

On the day of this unannounced surveillance audit there were 78 residents on site.

**Outcome 1.1: Consumer Rights**

Communication systems are effective. Staff are adhering to the principles of open disclosure and notifying families of any adverse events that impact their relatives. Families are advised as soon as practicable when there is a change in a resident's health status, and residents are advised and supported to undergo a review of their needs assessment when indicated. The communication needs of residents for whom English is a second language is provided for.

The complaint management process is transparent and understood. Residents and families are informed about how to raise a complaint. There is evidence that all complaints received are logged in the complaint register, investigated and resolved in a timely manner.

**Outcome 1.2: Organisational Management**

The organisation is maintaining its existing quality and risk management systems and is still engaged in external benchmarking. Organisational performance and service delivery continues to be monitored via internal audits and consumer feedback. There are effective health and safety systems in place.

Adverse events are reliably reported and notified to interested parties. Incidents and accident data is reviewed to identify the cause and any actions required to prevent recurrence.

Human resources are recruited and managed according to good employer practices. There is evidence that all new staff complete the orientation programme which contains appropriate and essential information and competency testing. Ongoing staff training is occurring regularly as planned and subject matters are relevant to the care being delivered.

Staffing numbers and the allocation of registered nurses (RNs) is more than what is required for the size and type of services being delivered. There are RNs on site each day and three senior management personnel are on site Monday to Friday. There is a RN on call 24 hours a day, seven days a week

**Outcome 1.3: Continuum of Service Delivery**

The service provides rest home and dementia care, which is clearly and accurately identified in pre-admission information. The service has policies and processes related to entry into the service.

Services are provided by suitably qualified and trained staff to meet the needs of residents. Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. The service meets the contractual times frames for the development of the long term care plan. When there are changes in the resident’s needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs of the resident. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided ensuring continuity of services. Referrals to other health and disability services is planned and coordinated as required based on the individual needs of the resident. The families interviewed report that interventions are consistently implemented and that the service manages the residents’ care needs.

The service has a planned activities programme to meet the recreational needs of the residents with a focus on residents with impaired cognitive function. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system is observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent.

Residents' nutritional requirements are met by the service. Residents’ likes, dislikes and special diets are catered for, with food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian.

**Outcome 1.4: Safe and Appropriate Environment**

The buildings, chattels and equipment are being maintained in good condition. There is a current building warrant of fitness.

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

The service is maintaining its policy and practice of no restraint. On the day of audit there are no residents requiring restraint or enablers.

**Outcome 3: Infection Prevention and Control**

There is a documented infection prevention and control programme which is approved and facilitated by the nurse manager and clinical coordinator. All required infection prevention and control policies and procedures are available for staff.

The clinical coordinator, who is the infection prevention and control co-ordinator, participates in relevant ongoing education. Relevant education is also provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurses and caregivers in a timely manner. Overall infection rates and trends are discussed at the infection prevention and control and monthly staff meetings.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 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 | 35 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

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

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There have been situations where residents for whom English is a second language have been assisted by staff who speak their language. External interpreter services have not been required since the previous audit but staff know how to contact these services if required. The service is maintaining its open disclosure practices and residents and their relatives interviewed state they are kept informed about all events. Review of incident and accident records reveal that families are notified as soon as possible about incidents which impact their family members. There has been one complaint by a family member about not being informed. Investigation into the complaint revealed that attempts were made to notify the family but reords of these attempts were not retained. Staff wear uniforms and name badges to assist residents and relatives with identification. The ARC requirements are met.

English as a second language have been assisted by staff who speak their language. External interpreter services have not been required since the previous audit but staff know how to contact these services if required. The service is maintaining its open disclosure practices and residents and their relatives interviewed state they are kept informed about all events. Review of incident and accident records reveal that families are notified as soon as possible about incidents which impact their family members. There has been one complaint by a family member about not being informed. Investigation into the complaint revealed that attempts were made to notify the family but reords of these attempts were not retained. Staff wear uniforms and name badges to assist residents and relatives with identification. The ARC 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 1.1.13: 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 system is well established and clearly understood by the staff, residents and relatives interviewed. Staff encourage residents and their families to raise any concerns or dissatisfaction at any time with the clinical manager and/or the general manager. There have been 39 complaints submitted in the past 22 months. The general manager ensures all matters are entered into the electronic complaint register as soon as they are received and that an acknowledgement letter is sent within 48 hours. The acknowledgement letter includes an anticipated date for futher communication. There have been three anonymous complaints to the Office of the Heath and Disability Commissioner related to resident falls and wandering since the previous certification audit in 2012. In each instance the service provider has responded to further investigation and corrective actions requested by Waikato District Health Board. The service is now analysing complaint information, auditing the complaint process and is continuing to work on actively reducing the number of preventable resident falls.

All residents and family members interviewed stated thay are satisfied with services and confirmed they know how to raise concerns/or complaints. The complaints policy and process has been updated and there are forms and information about how to raise complaints on display at the reception desk. The service complies with ARC requirements for D6.2 and D13.3h.

The complaints management system is well established and clearly understood by the staff, residents and relatives interviewed. Staff encourage residents and their families to raise any concerns or dissatisfaction at any time with the clinical manager and/or the general manager. There have been 39 complaints submitted in the past 22 months. The general manager ensures all matters are entered into the electronic complaint register as soon as they are received and that an acknowledgement letter is sent within 48 hours. The acknowledgement letter includes an anticipated date for futher communication. There have been three anonymous complaints to the Office of the Heath and Disability Commissioner related to resident falls and wandering since the previous certification audit in 2012. In each instance the service provider has responded to further investigation and corrective actions requested by Waikato District Health Board. The service is now analysing complaint information, auditing the complaint process and is continuing to work on actively reducing the number of preventable resident falls.

All residents and family members interviewed stated thay are satisfied with services and confirmed they know how to raise concerns/or complaints. The complaints policy and process has been updated and there are forms and information about how to raise complaints on display at the reception desk. The service complies with ARC requirements for D6.2 and D13.3h.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A new trustee has joined the board since the previous certification audit. Processes for board reporting have not changed. The CEO submits financial and narrative reports to the board each month. The two general managers submit narrative and statistical information on bed states including the number of admissions and discharges, staffing and activities including complaints and all incidents and accidents. The organisation has strategic and business plans which include values, service scope and clearly defined purpose and current goals. The CEO reports progress against each of the goals in the business plan at monthly board meetings.

There has been a significant restructuring of senior management. The CEO has been in the role for 17 years, but there are now two general managers. One who oversees the retirement village and all support services such as catering, cleaning, grounds and building maintenance and repair and the general manager for care services oversees resident care. This person is a NZ registered nurse with extensive experience including years as a caregiver and clinical co ordinator at Tamahere Rest Home. A clinical manager is employed for 40 hours per week who reports to the general manager. Review of the general manager of care services’s personnel records, reveals that this person holds a current practising certificate and is attending ongoing education relevant to managing a rest home.

##### **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 1.2.3: 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:**

Quality and risk continues to be managed using the Quality Performance System (QPS) external quality monitoring programme. Tamahere Eventide is submitting quality data such as staffing (absenteeism, attrition), resident aggression, restraint, resident falls (with and without injury), resident and staff accidents, infections and wounds to QPS every three months. Where the collated results show that Tamahere Rest Home is not tracking as well as other benchmarked services the managers initiate improvement projects. There is a new 20 hour per week quality role and this person is assisting managers to better utilise and improve the quality tools available. The quality person is ensuring that policies and documents are reviewed and updated as required.

There is evidence the quality management system is integrated with service delivery. All quality results are reported at a range of staff meetings. Review of meeting minutes reveals that health and safety, incidents/accidents, complaints, infections and challenging behaviours are discussed at monthly RN meetings and at quality and risk meetings. Internal audits are being conducted by the RNs. Where service deficits are identified through the internal audit system, or via an incident, a complaint or feedback from staff or residents and relatives, a range of corrective actions are discussed with relevant people and the most suitable actions are implemented. An example of this is the coordinated approach to reducing falls. There is now a post fall protocol which includes review of the fall event and actions to be taken to prevent future falls. More sensor mats have been purchased and are in use and new doors alarms notify staff when residents are up and wandering. Changes have been made to the food menu which now includes a milky dessert to assist with sleep and increasing calcium intake. The clinical team is focused on resident’s nutrition and is regularly calculating each resident’s body mass index (BMI) with an objective to have every residents BMI above 20. Quality data results reveal that falls have decreased from 42 in August to 27 in September and two falls in October. 27 of the 42 falls in August are attributed to the same resident who was living independently and refusing assistance until being brought into respite care. There is also an increase in diversional therapy hours in the secure unit.

Risk management processes are integrated with the quality monitoring system. The business risk management plan includes service provision, human resources, natural disaster planning, health and safety, contractual compliance and financial risks. Health and safety matters continue to be discussed at staff and management committee meetings. Environmental audits to assess for health and safety are conducted regularly and reactive facility maintenance occurs. The hazard register is being updated as new hazards are identified. Chemical safety data sheets which identify hazardous chemicals are available on site. All accident / incident reports are considered by a multidisciplinary team as a means of identifying and preventing avoidable risks. The new staff orientation / induction and topics in the annual staff education plan include health and safety and essential emergency processes as mandatory. The interRAI assessment process identifies each resident’s clinical risks and service delivery plans describe how these will be mitigated.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is systematic and reliable reporting of adverse events. All incident and accidents are reviewed by the general manager, care services and the clinical manager as soon as possible to determine if the incident was preventable and whether there is any ongoing risk. Dates, times and event descriptions are entered onto Netsoft (the integrated client management system) this data is then analysed for trends, to determine where improvements are required and then reported to staff and the board. Medicine errors are recorded and reported. There is a significant decrease in falls in the past three months of this year. This is largely attributable to one resident who was living independently and refusing assistance. The resident was transferred to rest home care and is now working toward returning to independent living.

##### **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:**

The organisation is using good employment practices to recruit, employ and manage its human resources. Personnel records reviewed contain evidence that reference and police checking occurs prior to confirmation of employment. All registered health professionals are maintaining their practising certificates.

Four care staff and the training coordinator interviewed and eight staff files viewed, confirm that all new staff complete an orientation programme specific to their role. A performance appraisal and competencies are carried out within 90 days of employment. The new care manager is on track to complete all staff appraisals now due.

Staff training continues to be well planned and co-ordinated. A new fit for purpose training room has been installed on site and a new part time training coordinator was appointed 12 months ago. There is evidence in the training attendance records and staff files sighted and in staff interviews that all staff are provided regular opportunities to attend training that is relevant and specific to the role they are employed for.

##### **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:**

Staffing numbers continue to be above what is required by the service provider’s contract with the DHB in both the rest home and the secure unit. There is a RN allocated for each area from 7am to 3.45pm and from 3.30 to 12 midnight. An extra RN is always on call. The secure unit RN works until 9.30pm. Three caregivers and a diversional therapist (7am to 8pm) are in the secure unit for 22 residents from 7am to 12 midnight, and one caregiver from 12am to 7am. This provides a staff to resident ratio of 1:4. There are six caregivers and two diversional therapists in the rest home during the day, and four caregivers in the afternoon, which provides a 1:6 staff to resident ratio. Two caregivers and an EN are allocated in the rest home from 12 midnight to 7am. There is a separate nurse allocated to residents in the retirement village. In addition there is a rehabilitation assistant and general manager and clinical coordinator who are RNs with practising certificates on site Monday to Friday 8am to 5pm. There are sufficient other auxiliary staff employed for the kitchen, cleaning, laundry, maintenance and grounds and administration roles.

##### **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.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by a RN who is competent to perform the function. The caregivers provide most of the direct personal care, with a number of the caregivers having completed the national qualification in the care of the older person. Staff have access to ongoing education that is relevant to delivering safe resident care. Practising certificates are sighted for all staff that require them.

The service has not yet commenced the use of the interRAI assessment, with one RN scheduled for training. The current paper based initial assessments and initial care plan covers the physical, psychosocial, spiritual and cultural needs of the resident. The initial assessment and initial care plan are developed on the day of admission, as confirmed in the six of six residents’ files reviewed. There is an initial care plan used for up to three weeks until the long term care plan is developed. The Tamahere Eventide Home and Village process for care planning includes an intergrated process, where the progress notes, assessment and care plan are incorporated. The care plans are a ‘living document’ and can be reviewed daily. The organisational time frames for the maximum period before the care plan review is three months, with care evaluation occurring at least six monthly (more frequently if there is a change in the resident’s needs). The nursing assessments are reviewed at least six monthly and when there is a change in the assessments, the care plan is updated to reflect the resident’s currents needs and required interventions.

The long term care plan format identifies the goals, interventions and the evaluation of the care. The needs identified on the long term care plan include assistance with personal care agreed with the resident (and where applicable the family), based on the resident’s assessed needs. Short term care plans identify the problem, aim, solution and review to evaluate if the interventions are working. The long term care plans record those who are consulted to contribute to the care planning (eg, resident, family, staff, key worker, diversional therapist, occupational therapist and physiotherapist). The six of six residents' files reviewed have the appropriate assessments, care plans and desired goals identified.

Interview with the RN and clinical manager (who is also a RN) confirms that the initial assessment and initial care plan are developed on the day of admission, the long term care plan is developed within three weeks and reviewed and evaluated at least six monthly. The residents are reviewed by a general practitioner (GP) at last three monthly, when the resident is assessed as stable. The four of four residents interviewed report a high level of satisfaction with the medical coverage and feel they are able to access the GP when they require.

Each resident has one file which includes the multidisciplinary team input into care. A daily record of care records interventions each shift. There is verbal handover between each shift. A communication book is also maintained to record appointments. The two RNs and four caregivers report that there is an adequate handover to provide information for the continuity of care and report an excellent team approach to care.

The four of four residents and two family/whanau interviewed report high satisfaction with the care provided at the service.

Tracer Methodology Rest Home:

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

Tracer Methodology Dementia Unit:

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

The DHB 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 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has adequate dressing and continence supplies to meet the needs of the residents.

The six of six care plans reviewed, record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The four residents and two family/whanau interviewed report that the service meets the needs of the residents.

The staff report on interview they are aware of resident’s specific needs and notified of changes at handover.

The DHB contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Tamahere Eventide Home and Village organisational diversional therapist oversees the activities programme and has four assistant activity coordinators. The service provides an activites programme seven days a week over twelve hours a day. The diversional therapist interviewed reports activities plans are individualised to the resident’s needs. The six of six residents' files reviewed have activities assessments and diversional therapy plans that are updated and evaluated in each resident's file at least six monthly (mostly monthly reviews are sighted) with care plan reviews and multidisciplinary reviews.

The service, being both rest home and dementia level of care, has some residents that are independent and participate in community activities. The planned activities are developed from resident input and are individualised to their needs, hobbies and special interests. The diversional therapist reports that they have a resident who likes gardening, and this resident has a garden at the facility, in which produce can be used at the facility. The activities assessments and plans are incorporated in to the long term care plan, as sighted in the six of six residents’ files reviewed. Evidence shows they are up to date and reflect individualised needs of the residents. The activities assessment includes social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests. Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the residents’ interests.

The four residents and two family members with relatives in the dementia unit interviewed report they/their relative enjoy the range and variety of planned activities. One resident did comment that they enjoy exercise programmes and reports it is their choice if they wish to attend.

All staff have the required NZ Qualifiation Authority (NZQA) units for working in the dementia unit (sighted).

The DHB contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The six of six (four rest home/two dementia) care plans reviewed evidence evaluations are recorded at least six monthly by the manager (RN), with input from the GP, the resident, the family and the activities coordinator. The documented evaluations indicate the resident's progress in meeting goals, and care plans are also updated to reflect progress towards meeting goals.

Where progress is different from expected the service either updates the long term care plan or uses short term care plans for temporary changes. The six of six residents' files reviewed indicate they are updated to reflect changing needs of the resident. The four residents and two family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.

The DHB contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.12: 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:**

Medicines for residents are received from the pharmacy in the blister pack delivery system monthly. The signing sheet that records the packs are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine trolleys that are secured to a wall. There is a monthly stock rotation recorded for the medicines that are not packed in the blister packs. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken. There is an additional six monthly stock count.

The sixteen of sixteen medicine charts reviewed have been reviewed by the GP in the last three months and this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose and time of administration. All medicine charts reviewed have each medicine individually prescribed and allergies recorded. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for the staff designated as responsible for medicine management.

The RN reports that there are no residents who self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.

The DHB contract 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 menu is reviewed and approved by a registered dietitian in March 2014 as suitable for aged care residents. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic meals and food for a resident with an allergy.

The service is managed by the hospitality manager who employs three cooks over seven days. They are supported by four kitchen hands. Evidence is seen of all kitchen staff having completed safe food handling certificates and ongoing in house education.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging.

Resident satisfaction survey are completed three monthly and any concerns are follow up and reported at resident meetings (sighted).

The DHB contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

#### Standard 1.4.2: 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:**

All buildings, plant and equipment comply with regulations and legislation. The building warrant of fitness is current and expires on 23 July 2015. There have been improvements to the facility but no changes to the structure of the buildings. Changes include a reconfiguration to the main reception area, the opening of café and recreation area for all residents and families to access, newly configured offices and meeting rooms. The physical environment is appropriate to the needs of older people and identified hazards are eliminated where possible. The external areas inspected are safe for use by older people.

##### **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.)*

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The service is maintaining its philosophy and practice of no restraint. There are systems and processes for implementation if restraint is required. When a resident's condition deteriorates and their safety is compromised, they are reassessed for transfer to another more appropriate service as evidenced in interview with the general manager and chief executive and review of incident accident reports and staff meeting minutes. There are no voluntary enablers in use. Staff training on restraint prevention occurs regularly.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

#### Standard 3.5: 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:**

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The monthly report of collected data is provided to senior management and presented at quality and staff meetings. Infection control data is included in the quality audit programme and the data is benchmarked with an external agency. There is a quarterly quality management meeting that is overseen by an external consultant in infection prevention and control (minutes sighted), where the data is reviewed and analysed.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken.

##### **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.)*