# Harbour View Rest Home (2005) Limited

## Current Status: 22 October 2013

**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

Harbour View rest home is owned and operated by a husband and wife team. One owner is the designated manager. The manager is supported by a clinical coordinator, registered nurses and care staff. The service is certified to provide rest home and dementia care for up to 42 residents. On the days of audit there were 24 rest home residents and 17 residents in the dementia unit. Harbour View has clearly defined goals and objectives for business management and resident service delivery. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 10 years and is an experienced health administrator. Residents and families interviewed were complimentary of the care and support provided.

This audit identified areas of improvement required relating to ensuring professional boundaries are maintained, clinical follow up following incidents and accidents, medication competencies, appraisals for registered nurses, orientation to the dementia unit programme, corrective fluid on documentation, assessments for clinical risks and wounds and aspects of care plan documentation.

## Audit Summary as at 22 October 2013

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 22 October 2013

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

### Organisational Management as at 22 October 2013

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

### Continuum of Service Delivery as at 22 October 2013

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

### Safe and Appropriate Environment as at 22 October 2013

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| 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 22 October 2013

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| 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 22 October 2013

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| 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 22 October 2013

### Consumer Rights

Harbour View rest home strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. One improvement is required whereby professional boundaries are upheld in relation to rest home residents residing in the down stairs area of the facility. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented. A complaints register is maintained.

### Organisational Management

The quality and risk management programme includes service philosophy , goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following audits. Key components of the quality management system link to monthly management meetings and monthly staff meetings. Residents meetings are held six weekly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Reporting of and investigations into incidents and accidents occurs, however, there is an improvement required relating to clinical follow up of residents following injury. There is an induction programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Improvements are required relating to registered nurse performance appraisal content and review of medication competencies for registered nurses.

### Continuum of Service Delivery

The service has a policy for admission and entry for the rest home and dementia care unit. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The registered nurse (RN) and/or clinical coordinator (RN) are responsible for each stage of service provision. There is a requirement to provide evidence of resident/family/whanau involvement in the care planning process. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. There is an improvement required around the use of short term care plans and evaluation of short term care plans for short term needs and long term care plans.

The residents' needs, interventions, objectives/goals have been identified in the long term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required to ensure that that the nursing care evaluations are signed and dated by the registered nurse completing the review. There is evidence in the resident files that there is resident and/or family/whanau input into the development and review of care plans. Resident files are integrated and include notes by the general practitioner (GP) and allied health professionals.

There is a varied and interesting activity programme of activities, outings and entertainment that meets the group and individual interest, abilities and preferences. Community links are maintained and there are a number of volunteers who interact socially with the residents.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration.

Food services and all meals are provided on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

### Safe and Appropriate Environment

The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home. There are separate lounge and dining areas in the dementia care unit appropriate to meet the individual needs. There is a secure outdoor walking path and garden area for the dementia area. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen, laundry and cleaners cupboard. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

### Restraint Minimisation and Safe Practice

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day.

### Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

# HealthCERT Aged Residential Care Audit Report (version 3.9)

## **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**

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| --- | --- |
| **Legal entity name:** | Harbour View Rest Home 2005 Ltd |
| **Certificate name:** | Harbour View Rest Home |

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| **Designated Auditing Agency:** | HDANZ |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | Harbour View Rest Home, Waterfront Road, Oamaru | | | |
| **Services audited:** | Rest home, Dementia | | | |
| **Dates of audit:** | **Start date:** | 22 October 2013 | **End date:** | 23 October 2013 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 41 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 13 | Total audit hours | 37 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 32 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, Director of Christchurch 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:

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| --- | --- | --- |
| 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 Auditing Agency has finished editing the document. | Yes |

Dated Monday, 25 November 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Harbour View rest home is owned and operated by a husband and wife team. One owner is the designated manager. The manager is supported by a clinical coordinator, registered nurses and care staff. The service is certified to provide rest home and dementia care for up to 42 residents. On the days of audit there were 24 rest home residents and 17 residents in the dementia unit. Harbour View has clearly defined goals and objectives for business management and resident service delivery. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 10 years and is an experienced health administrator. Residents and families interviewed were complimentary of the care and support provided.  This audit identified areas of improvement required relating to ensuring professional boundaries are maintained, clinical follow up following incidents and accidents, medication competencies, appraisals for registered nurses, orientation to the dementia unit programme, corrective fluid on documentation, assessments for clinical risks and wounds and aspects of care plan documentation. |

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| **Outcome 1.1: Consumer Rights** |
| Harbour View rest home strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. One improvement is required whereby professional boundaries are upheld in relation to rest home residents residing in the down stairs area of the facility. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are actively managed and well documented. A complaints register is maintained. |

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| **Outcome 1.2: Organisational Management** |
| The quality and risk management programme includes service philosophy , goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following audits. Key components of the quality management system link to monthly management meetings and monthly staff meetings. Residents meetings are held six weekly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Reporting of and investigations into incidents and accidents occurs, however, there is an improvement required relating to clinical follow up of residents following injury. There is an induction programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Improvements are required relating to registered nurse performance appraisal content and review of medication competencies for registered nurses. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a policy for admission and entry for the rest home and dementia care unit. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The registered nurse (RN) and/or clinical coordinator (RN) are responsible for each stage of service provision. There is a requirement to provide evidence of resident/family/whanau involvement in the care planning process. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. There is an improvement required around the use of short term care plans and evaluation of short term care plans for short term needs and long term care plans.  The residents' needs, interventions, objectives/goals have been identified in the long term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required to ensure that that the nursing care evaluations are signed and dated by the registered nurse completing the review. There is evidence in the resident files that there is resident and/or family/whanau input into the development and review of care plans. Resident files are integrated and include notes by the general practitioner (GP) and allied health professionals.  There is a varied and interesting activity programme of activities, outings and entertainment that meets the group and individual interest, abilities and preferences. Community links are maintained and there are a number of volunteers who interact socially with the residents.  Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration.  Food services and all meals are provided on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Communal areas are spacious and well utilised for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home. There are separate lounge and dining areas in the dementia care unit appropriate to meet the individual needs. There is a secure outdoor walking path and garden area for the dementia area. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely in the kitchen, laundry and cleaners cupboard. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There were no residents requiring restraint or enabler use at the facility on audit day. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 38 | 0 | 2 | 5 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 4 | 4 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 7 | 0 | 1 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.7: Discrimination | Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The risk of professional boundaries being breeched is raised due to two residents being able to access private living quarters in the down stairs area of the rest home. | Ensure that residents and staff are not put at risk and that professional boundaries are upheld in relation to access to private living quarters in the down stairs area. | 90 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Clinical observations were not conducted for two residents following falls and possible head injury. | Ensure clinical observations are conducted and documented for all residents with suspected head injuries. | 30 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Advised that the orientation programme for the dementia unit is relevant and includes a session on how to implement activities and therapies, however, this is not recorded on the orientation checklist. | Review orientation documentation and provide evidence that activities programme orientation is included in the process of orientation on new staff to the dementia unit. | 90 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | (i) RN appraisals do not align with NCNZ competencies for registered nurses and are conducted by the manager; (ii) Medication competency does not include controlled drug medication management (iii) Medication competency assessment has not been completed by the clinical coordinator. | (i) Review RN appraisals to align with NCNZ competencies for registered nurses and ensure clinical aspects are appraised by an RN; (ii) Review the medication competency package to include controlled drug medication management; (iii) Ensure the clinical coordinator completes an annual medication competency. | 60 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Low | There is evidence of the use of corrective fluid on documents reviewed including incident reports, care plans, and care plan evaluations. | Cease the practice of using corrective fluid on all documentation. | 30 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i)Two of four wound assessment and treatment plans reviewed did not document the type of wound being treated. | Ensure wound care assessments are fully completed. | 60 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | (i)Two of three dementia resident care plans reviewed who have challenging behaviours did not document the management strategies that could be utilised by staff to prevent/manage or distract from the behaviours.  (ii) A short term care plan was not completed for a resident with a wound infection who has been commenced on Antibiotics. | Ensure that behaviour management strategies are documented in residents care plans for those residents with behaviours that are challenging. (ii)Ensure that short term care plans are used to document any changes in health needs with interventions, management and evaluations. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Completed care plan evaluations forms were not evidenced to be signed or dated by the registered nurse completing the evaluation. (ii) Short term care plans were not dated when resolution of the acute issue had been resolved or transferred into the long term care plan. | Ensure care plan evaluation forms are signed and dated by the RN completing the evaluation. (ii) Ensure short term care plans are evaluated and dated by the RN when resolution has occurred. | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Code is incorporated into everyday care. Discussions with six caregivers from the rest home and dementia units, identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with four rest home residents and six family members (three rest home and three dementia) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in October 2013. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Code of rights leaflets are available at the front entrance of the facility. Code of rights posters are on the walls in the hallway of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in seven of seven files reviewed (four rest home and three dementia). D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and H&D Commission. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values. Interventions to support these are identified and evaluated. The home's philosophy which states: “In partnership – we are committed to providing the highest quality holistic care and services for our residents, which exceed their expectations. Vision and Values include respect for the dignity, beliefs and abilities of every individual, showing tolerance, recognising individual needs and treating others as equals; caring and compassion; integrity; unity and discovery. One married couple reside in the dementia unit – one is a rest home resident and one is dementia resident. The rest home resident advised that he is quite happy residing in the dementia unit, he attends activities as he chooses and is happy to be sharing a room with his wife. No other rest home residents reside in the dementia unit. There is a policy that covers abuse and neglect and staff have completed training in October 2013. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. E4.1a Three families state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.  D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness training occurred as part of the annual in-service education programme in March 2012. A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The service has developed links with local iwi. There are currently no Maori residents at Harbour View rest home. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service's philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby enabling residents to be individuals. This flows through into each person’s care plan and could be described by six caregivers interviewed. During the admission process, the registered nurses along with the resident and family/whanau complete the documentation. Regular reviews are evident and the involvement of family/whanau is recorded in the resident care plan. Six family members interviewed (three rest home and three dementia) feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. D3.1g The service provides a culturally appropriate service by implementing the Harbour View rest home vision and values which includes: respect for the dignity, beliefs and abilities of every individual, showing tolerance, recognising individual needs and treating others as equals; caring and compassion; integrity; unity and discovery. D4.1c Seven care plans reviewed (four rest home and three dementia) included the residents social, spiritual, cultural and recreational needs. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with four residents identify that privacy is ensured. Discussions with six caregivers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature.  Two rest home residents reside in the down stairs area of the rest home. The activities coordinator also resides in the area in a private apartment. Advised that the rest home residents are able to, and do, access the lounge area of the apartment occupied in the private quarters as the door is not locked. This raises the issue of the risk of professional boundaries being crossed and inappropriate access by residents to the private living area of the tenant. Advised by the manager that the tenancy will not be renewed in 2014. Improvements are required in this area. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with four residents identify that privacy is ensured. Discussions with six caregivers described how professional boundaries are maintained. Discussions with the manager and a review of complaints identified no complaints of this nature. |
| **Finding:** |
| The risk of professional boundaries being breeched is raised due to two residents being able to access private living quarters in the down stairs area of the rest home. |
| **Corrective Action:** |
| Ensure that residents and staff are not put at risk and that professional boundaries are upheld in relation to access to private living quarters in the down stairs area. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are reviewed annually by the manager to maintain best practice. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through residents meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. There is an internal audit schedule. Four rest home residents and six family members (three rest home and three dementia) interviewed spoke very positively about the care provided. Quality activities are reported and discussed at management meetings and staff meetings.  D1.3 All approved service standards are adhered to. D17.7c. There are implemented competencies for the care givers and registered nurse including medication management, restraint, infection control and syringe drivers for RN’s. Medication competencies require improvements as per finding in #1.2.7.4. There are clear ethical and professional standards and boundaries within job descriptions . |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy, a complaints policy, and an incident reporting policy. Four residents and six family members (three rest home and three dementia) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur six weekly and the manager and clinical coordinator have an open-door policy.  All report forms sighted for July and September 2013 were completed and family notified as appropriate.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b The six family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.  The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available. D11.3 The information pack is available in large print and advised that this can be read to residents. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The informed choice and consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process and at resident reviews. Caregivers interviewed (six) are familiar with the code of rights and informed consent and described the link between the rest home's philosophy and choice and consent on a daily basis. Informed consent forms are evident on seven of seven resident files reviewed (four rest home and three dementia). There is a resuscitation policy and resuscitation decision form that is completed appropriately. Resuscitation orders are completed for residents who are competent to make the decision. The admission agreement records informed consent and this is signed by residents and/or family.  D13.1 There were seven admission agreements sighted and all evidence signing.  D3.1.d Discussion with six family members identifies that the service actively involves them in decisions that affect their relatives lives. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Client right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information.  Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided in October 2013. D4.1d; Discussion with four residents and six family members identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services. D4.1e: Seven of seven resident files reviewed includes information on residents family/whanau and chosen social networks. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D3.1h Discussion with the manager, clinical coordinator, registered nurse, six caregivers, four residents and six family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours. D3.1.e On interview, the activities coordinator described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens e.g. voting / census. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, attending church services. Entertainers are included in the home's activities programme. Outings in the facility owned van are tailored to meet the interests of the residents. |

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

Consumers have access to visitors of their choice.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. Two complaints have been received for 2013 and relate to a resident’s clothing and a respite resident’s medication. A review of the complaints folder evidences that these concerns from residents have been documented and managed. One further complaint was reviewed which was initiated in 2011 and has been investigated by the Health and Disability Commissioner’s office and the Southern DHB. There are records of correspondance and reports from an independent registered nurse. As of June 2013, the DHB has indicated that the complaint is resolved and no further action will be taken. Both verbal and written complaints are actively managed. There is a complaints register and this has been utilised for documenting complaints or concerns. Four residents and six family members advised that they are aware of the complaints procedure and how to access forms. D13.3h. A complaints procedure is provided to residents within the information pack at entry E4.1biii.There is written information on the service philosophy and practices particular to the King George dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Harbour View rest home is privately owned and operated by a husband and wife team. One owner is the manager. The service is certified to provide rest home and dementia specific care to up to 42 residents – 24 rest home and 18 dementia. On the days of audit there were 24 rest home residents and 17 dementia specific residents. One rest home resident resides in the dementia unit with his wife – which has been approved by the DHB. Harbour View has clearly defined goals and objectives for business management and resident service delivery. The mission statement and vision and values of the services include promoting residents independence, respecting cultural values and providing a caring homelike environment. Annual review of the quality and risk management programme is conducted. The manager has been in the role for over 10 years and is an experienced health administrator. The manager has attended in excess of eight hours professional development in 2013. E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. D17.3di (rest home) The manager has maintained at least eight hours annually of professional development activities related 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During a temporary absence of the manager, the facility is managed by the clinical coordinator. The manager is experienced in rest home management and has been in the role for the past 10 years. The clinical coordinator (a registered nurse) is experienced in aged care, palliative care and management and has been in the role for 3 ½ years . The service has well developed policies and procedures at a service level and a strategic plan and quality improvement plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home and dementia specific level care. D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service has operational management strategies and a QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The management manual includes the business, quality and risk management plan and service philosophy. The quality programme is reviewed annually (last conducted February 2013). The quality and risk management plan has documented aims with implemented activities for each aim. Aims for the service include: a consumer focus, provision of effective programmes, certification and contractual requirements, risk management, and continuous improvement. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly management meetings, and monthly staff meeting. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Management meeting minutes sighted for 3 October 2013 and staff meeting minutes for 17 October 2013.  Minutes include actions to achieve compliance where relevant. Discussions with the registered nurses and care givers confirm their involvement in the quality programme. Resident/relative meetings take place six weekly. Internal audits are conducted and include: safety, pressure area risk, recreation programme, care/hygiene of residents, infection control, challenging behaviour management, laundry service, cleaning, privacy of information, restraint, medication management and storage, building compliance, civil defence kit and care plan audit. Audits for 2012 and 2013 have been completed and there is documented management around non-compliance issues identified.  Finding statements and corrective actions have been documented. A resident and family survey conducted in June 2013 evidences that families are over all very satisfied with the service. A survey evaluation has been conducted for follow up and corrective actions required. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Quality improvements are documented as identified through the quality activities. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. D5.4 The service has policies and procedures to support service delivery; Policies and procedures align with the client care plans. The owner/manager is responsible for policy review. D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g Falls prevention strategies include exercise programme, education for staff, residents and families, falls risk assessment, walking aids, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is an accidents and incidents reporting policy. Accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly management and monthly staff meetings including actions to minimise recurrence. Incident/accident forms are completed by caregivers and RN’s and given to the clinical coordinator who initiates any additional follow up. The manager collates and analyses data to identify trends. Discussions with the manager and clinical coordinator confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Incident reports for July and September 2013 were reviewed and included the following samples. One resident who fell and sustained bruises and a skin tear including a head laceration. There is no evidence that neurological observations were conducted following the incident. One dementia resident with nine incidents of aggression/agitation has had appropriate review and follow up and is currently being reassessed in an acute setting. One rest home resident (new admission) reported missing three times; appropriate actions were taken including meeting with family and mental health support worker – the resident is now settled and no further incidents reported. One rest home resident with two falls including a head injury, and two behaviour incidents. Falls risk assessment review not conducted as per finding #1.3.4. Clinical observations were not conducted. Improvements are required in this area.    D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Incident reports were reviewed and included the following samples. One resident who fell and sustained bruises and a skin tear including a head laceration. One dementia resident with nine incidents of aggression/agitation has had appropriate review and follow up and is currently being reassessed in an acute setting. One rest home resident reported missing three times; appropriate actions taken including meeting with family and mental health support worker – the resident is now settled and no further incidents reported. One rest home resident with two falls including a head injury, and two behaviour incidents. Falls risk assessment review not conducted as per finding #1.3.4. |
| **Finding:** |
| Clinical observations were not conducted for two residents following falls and possible head injury. |
| **Corrective Action:** |
| Ensure clinical observations are conducted and documented for all residents with suspected head injuries. |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are human resource management policies in place which includes recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the clinical coordinator, registered nurses, dietitian, podiatrist and general practitioners is kept. The human resources policies also include orientation, staff training and development. Six staff files were reviewed (one clinical coordinator, one registered nurse, one rest home care giver, two dementia unit care givers, and one cook). Advised that reference checks are completed before employment is offered as evidenced in two recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in three of six staff files reviewed. Discussion with the manager, clinical coordinator, registered nurse and six caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. The annual training programme exceeds eight hours annually. Six caregivers interviewed have either completed the national certificate in care of the elderly or have either completed or commenced the aged care education programme. The clinical coordinator is responsible for facilitating the ACE programme with caregivers. The manager, clinical coordinator and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB. Education provided in 2013 includes: Code of Consumer Rights and advocacy, complaints management, hydration, fire training, wound cares, infection control, challenging behaviours, open disclosure, first aid, hand washing, pain management, continence management. In 2012 the programme included (but not limited to): chemical safety, cultural safety, sexuality and intimacy. Restraint minimisation and competency was last conducted in October 2011 and is planned for November 2013. Fire evacuation drill last conducted 20 August 2013. On review of six staff files, performance appraisals for four of six staff have been conducted (two staff whose files were reviewed, have been employed within the past 12 months). It is noted that the manager has conducted the registered nurse appraisal which includes clinical review and that RN appraisals do not align with Nursing Council of New Zealand registered nurse competencies. Improvements are required in this area. Medication competencies are conducted annually for all clinical staff with medication responsibilities. The competency package is tailored to care givers and is completed by registered nurses. The clinical coordinator has not completed a medication competency. The competency package does not include controlled drugs storage, administration and management. Improvements are required in this area.  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication administration and syringe driver use.  E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies – however, this is not recorded on the orientiation checklist. Improvement is required in this area. E4.5e Agency staff are not utilised.  E4.5f There are 15 caregivers who work in the King George Dementia unit, five have completed the required dementia standards, six caregivers are in the process of completing and four are yet to start. Of those caregivers that are yet to start, all four have commenced employment within the last six months. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Six caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in three of six staff files reviewed. Discussion with the manager, clinical coordinator, registered nurse and six caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013. Advised that the orientation programme for the dementia unit is relevant and includes a session how to implement activities and therapies. Three caregivers who work in the dementia unit described their involvement in the activities programme. |
| **Finding:** |
| Advised that the orientation programme for the dementia unit is relevant and includes a session on how to implement activities and therapies, however, this is not recorded on the orientiation checklist. |
| **Corrective Action:** |
| Review orientation documentation and provide evidence that activities programme orientation is included in the process of orientation on new staff to the dementia unit. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| On review of six staff files, performance appraisals for four of six staff have been conducted (two staff whose files were reviewed, have been employed within the past 12 months). Medication competencies are conducted annually for all clinical staff with medication responsibilities. The competency package is tailored to care givers and is completed by registered nurses. There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to): medication administration and syringe driver use. |
| **Finding:** |
| (i) RN appraisals do not align with NCNZ competencies for registered nurses and are conducted by the manager; (ii) Medication competency does not include controlled drug medication management (iii) Medication competency assessment has not been completed by the clinical coordinator. |
| **Corrective Action:** |
| (i) Review RN appraisals to align with NCNZ competencies for registered nurses and ensure clinical aspects are appraised by an RN; (ii) Review the medication competency package to include controlled drug medication management; (iii) Ensure the clinical coordinator completes an annual medication competency. |
| **Timeframe (days):** 60 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and dementia unit residents. At least two staff are rostered on at any one time with one staff on-call. Senior caregiver, registered nurse or manager provide first on call and share this week about. Advised that extra staff can be called on for increased resident requirements. Interviews with six caregivers, four rest home residents and six family members (three rest home and three dementia) identify that staffing is adequate to meet the needs of residents. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in either the rest home or dementia unit nurses station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. D7.1 Entries are legible, dates and signed by the relevant care giver or RN including designation however, it is noted that on numerous documents (incident reports, care plans and care plan evaluations), the service has used corrective fluid to correct documentation errors. Improvements are required in this area.  Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| On review of seven resident files there is evidence that entries are legible, dated and signed by the relevant care giver or RN including designation. Progress notes are recorded on a computer programme and printed out into the resident file. |
| **Finding:** |
| There is evidence of the use of corrective fluid on documents reviewed including incident reports, care plans, and care plan evaluations. |
| **Corrective Action:** |
| Cease the practice of using corrective fluid on all documentation. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

All records pertaining to individual consumer service delivery are integrated.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The needs assessment coordination service (NASC) ensures all residents are assessed prior to entry for rest home or dementia level of care. A placement authority form is sent to the receiving facility. The clinical coordinator (RN) is responsible for the screening of residents to ensure entry has been approved. The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy.  E4.1.b There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. The registered nurse or clinical coordiantor on duty completes all the admission documentation and relevant notifications of entry to the service. Currently there is a waiting list for rest home beds. Four residents (rest home) and six relatives (three dementia and three rest home) interviewed state they received all relevant information prior or on admission. The GP and pharmacy are notified of the new admission. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Signed admission agreements were sighted. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. E3.1 Three resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Harbour View has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member is informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse undertakes the assessments on admission, with the initial RN assessment completed within 24 hours of admission. An initial care plan is also completed on admission. The admission information, medical notes, allied health notes, progress notes, staff input, resident and family input form the basis of the long term care plan developed within three weeks of admission. The activities assessment is competed within two weeks of admission.  monitoring. Residents retain their own GP's and there are a number of GP's that provide medical services.  A range of assessment tools completed on admission are evident in the six resident files sampled.  There is a verbal handover between shifts and written handover sheet with resident significant events documented. Daily progress notes are written on the computer and are maintained.  All seven files identified integration of allied health professionals including GP medical notes, podiatry notes, letters and referrals to other allied health professionals and specialists.  D16.2, 3, 4: The seven resident files reviewed identified that in all files a nursing assessment was completed within 24 hours and the long term care plan was completed within three weeks. There is documented evidence in resident files sampled that the care plans are reviewed by an RN,  Resident files sampled evidenced written evaluations are completed, however as the care plan evaluation was not dated by the RN it was difficult to assess the timeframe for completion. (link to 1.3.5)  D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident three monthly and records the resident as stable and to be seen three monthly. More frequent examination occurs when a resident health status changes.   Four rest home resident files are sampled.  Three dementia resident files sampled.   Tracer Methodology:  Rest home XXXXXX *This information has been deleted as it is specific to the health care of a resident*  Tracer  Dementia unit XXXXXX *This information has been deleted as it is specific to the health care of a resident* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care, photograph for ID and display, transport and outings, family involvement in assessment, care plans and evaluation of care plans, resuscitation. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, and long term care plan within the required timeframes. All resident files sampled (four rest home and three dementia care) evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives (three rest home, three dementia care) and residents (six rest home) advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to): continence, falls risk, pressure area risk, nutrition, pain and challenging behaviours. There are improvements required around the completion of wound care assessments. ARC E4.2; Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements. E4,2a Challenging behaviours assessments are completed. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care, photograph for ID and display, transport and outings, family involvement in assessment, care plans and evaluation of care plans, resuscitation. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, and long term care plan within the required timeframes. All resident files sampled (four rest home and three dementia care) evidenced an initial assessment and care plan with reference to the information gathered on admission. |
| **Finding:** |
| (i)Two of four wound assessment and treatment plans reviewed did not document the type of wound being treated. |
| **Corrective Action:** |
| 1. Ensure wound care assessments are fully completed. |
| **Timeframe (days):** 60 *(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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse or clincial coordinator develops the long term care plan from information gathered over the first three weeks of admission. The resident long term care plan has categories of care as follows:personal hygiene. eliminating, eating and drinking, mobilising, expressing sexuality/spirituality/culture, medication, controlling pain, sleeping patterns/rest, communication, skin/woundcare, breathing, memory loss confusion, challenging behaviour, special needs. The integrated resident file also contains the admission documentation,informed consent forms and advance directives, care documents, risk assessment tools and reviews, medical documents , test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence.  D16.3k, Short term careplans are available for use to document any changes in health needs. Short term care plans were evidenced utilised for urinary tract infections and wounds. There is an improvement required around the use of short term careplans for short term needs. One of three dementia residents care plans reviewed with challenging behaviours documented behavioural management strategies and this is also an area requiring improvement. Medical GP notes and allied health professional progress notes are evident in the seven residents integrated files sampled. Relatives (four rest home, four dementia care) interviewed are positive and complimentary about the staff, clinical and medical care provided . They confirm they are kept informed of any significant events and changes in health staus.  E4.3 Three resident files reviewed identified current abilities, level of independence and identified needs.There is an improvement required around the documenting of behaviour management strategies in care plans. There are regular visits from the Nurse Practitioner from Southern DHB. |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Short term careplans are available for use to document any changes in health needs with interventions. One of three dementia residents care plans reviewed with challenging behaviours documented behavioural management strategies. |
| **Finding:** |
| (i)Two of three dementia resident care plans reviewed who have challenging behaviours did not document the management strategies that could be utilised by staff to prevent/manage or distract from the behaviours.  (ii) A short term care plan was not completed for a resident with XXXXX. |
| **Corrective Action:** |
| 1. Ensure that behaviour management strategies are documented in residents care plans for those residents with behaviours that are challenging. (ii)Ensure that short term care plans are used to document any changes in health needs with interventions, management and evaluations. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service has been provided. Wound assessment and wound management plans are in place for four residents. (link to 1.3.4) The registered nurse and clinical coordinator interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One chronic wound reviewed evidenced input from the Tissue Viability Nurse Sounthern DHB. The wound management plan formulated from this visit was evidenced to be followed from the documentation reviewed. Residents' care plans are completed by the registered nurse or clinical coordinator (RN). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The six caregivers interviewed (three dementia care , three rest home ) who work across all shifts and stated that they have all the equipment referred to in the long term plans necessary to provide care, including hoists, pressure relieving mattresses and cushions, shower chairs, transfer belts, slippery sams, wheelchairs, gloves, aprons and masks.  D18.3 and 4 Dressing supplies are available and a stock of dressing supplies is kept in the clinical coordinators office. All staff report that there are adequate continence supplies and dressing supplies. There are short term care plans are used for minor wounds such as skin tears.  A physiotherapist is involved in manual handling education and resident assessments as required by referral. The podiatrist visits six weekly. The service has access to the Community Dietitian at Oamaru Hospital and contracted the services of a dietitian to review the menu planner. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A comprehensive social history is complete on or soon after admission and information gathered is included in the care plan. Residents are quick to feedback likes and dislikes to the activity coordinators. Feedback is also received from the resident meeting and satisfaction surveys. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly. Caregivers were observed various times through the day diverting residents from behaviours in the King George Wing (dementia unit).  There are two activities coordinators and one is completing the diversional therapy training. Actiivities are provided seven days a week. The programme is planed monthly for the rest home and dementia care unit. The RNs inform the activitiy coordinators if there are any changes to a residents physical and cognitive wellbeing that may have an impact on their level of participation in the activity programme. Residents are encouraged to maintain links with community groups such as the RSA, primary schools, kindergarten and church groups. The service has 15-20 volunteers who assist with the activities programme. Volunteers are involved in the home assist with games, puzzles, housie, exercises, walking groups, entertainment and outings. The mens group have enjoyed outings to play mini golf, workshops, the tool shed and the local pub/diner. Visitors to the home include musical entertainers, pet therapy and manacurist. The facility has a hairdressing salon which resdients and the local community use. The facilty has a van for ourings. There are twice weekly outings and interhome visits, shopping and library visits are enjoyed. Activites in the dementia unit are based on individual abilties and include sensory stimulation and household tasks that include feeding the birds, flower arrainging, setting tables, dusting reminiscing and photo books. There are suggestions of activities on the programme for morning, afternoon and evening times which staff can use when the activities coordinators are not available. Residents interviewed described being involved in crafts such as pottery, stone carving and painting. They also reported that they get ‘out and about” and enjoy the weekly van rides.  Residents in the dementia unit were observed enjoying a visit from entertainers who played the guitar and sang and also an afternoon tea dance. In the rest home residents were also being entertained by a different musician and were visited by a volunteer who was observed having some one on one with resdients. D16.5d Resident files reviewed identified that the individual activity plan is reviewed during care plan review. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The registered nurse or clinical coordinator completes a care plan evaluation form prior to six monthly care plan review.  D16.4a Six monthly evaluations of the long term care plan are conducted and involve the GP, clinical coordiantor or RN, caregivers, activities coordinator, resident/family/whanau input. The resident/family are notified of the review by letter and invited to attend. There is an improvement required aorund the completion of care plan evalaution forms. The long term support plan is amended with each review if there are changes. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were evidenced in use. Short term care plans are available. However there is an improvement required around the evaluation of short term care plans. ARC D16.3c: All initial care plans were evaluated by the RN within three weeks of admission. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A care plan evaluation form is completed by the RN or clinical coordinator as part of the six monthly care plan review. It was difficult for the auditor to confirm if the care plan evaluation had been completed within a six monthly timeframe due to care plan evaluations not being dated or signed by the registered nurse. Short term care plans are utilised for acute changes in resident’s needs. |
| **Finding:** |
| 1. Completed care plan evaluations forms were not evidenced to be signed or dated by the registered nurse completing the evaluation. (ii) Short term care plans were not dated when resolution of the acute issue had been resolved or transferred into the long term care plan. |
| **Corrective Action:** |
| 1. Ensure care plan evaluation forms are signed and dated by the RN completing the evaluation. (ii) Ensure short term care plans are evaluated and dated by the RN when resolution has occurred. |
| **Timeframe (days):** 60 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Referral to other health and disability services is evident in sample group of resident files. One resident’s file reviewed with a wound evidenced referral to and a visit from the Tissue Viability Nurse at Dunedin Hospital. One dementia resident has been referred for resassessment to possible higher level of care. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; community psychiatric nurse for older health, district nurse, speech language therapist, physiotherapist, podiatrist, General Practitioner and hospice . There is evidence of GP discussion with families reegarding referrals for treatment and options of care.  D16.4c; The service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with registered nurse and clinical coordinator identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian and other allied health professionals. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical coordinator, registered nurse and caregivers interviewed described the documentation (resuscitation form, medication chart, progress notes, and GP notes) that would be sent with a resident on transfer to hospital or another facility. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in residents record recently transferred back to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.5.e.i.2 Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals, blister packed medications and collects the returns. Medications are checked and signed by an RN on delivery. Any discrepancies are fed back to the pharmacy. The RN's and senior caregivers undergo a medication competency annually and attend annual education. However, the medication comptency does not include competency around controlled medications. (link to #1.2.7)  The controlled drug stock is checked weekly. There is a six monthly pharmacy audit. The locked medication trolley for the dementia unit and rest home is kept in the locked clinical cordinators office which is in the dementia unit. The medication fridge is monitored weekly. The RN carries out a weekly check on prn stock. There are no residents self administering medications. Caregivers are required to contact the RN prior to administering prn medictions. The lunchtime medication round observed in the dementia unit and tea time medication round observed in the rest home met medication safety standards.  Fourteen resident medication charts (eight rest home, six dementia ) identified all charts had photo identification and allergies/adverse reactions noted. There is evidence of three monthly GP review of medications. The medication folder contains information and precautions for specific medications. Staff sign a signing register and the medication signing sheets are all correct. PRN medications have the times given documented. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.2 Staff have been trained in safe food handling. Food services policies and procedures manual is in place. There is a cook on duty each day with an afternoon kitchenhand to serve tea. There is a five weekly summer and winter menu that is reviewed by a dietitian. The company dietitian is readily available to the cook by email/phone for advice if required.  All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a notice board and folder of residents likes/dislikes and alternative choices are offered. The cook is informed of dietary changes such as high calorie/high protein diets. Dietary needs are met including normal, soft, pureed, vegetarian. The main meal is midday lunch. The meals are served from the bain marie directly to the residents in the rest home dining room. Meals are transorted in the portable bain marie to a servery hatch in the rest home dning area that opens onto the dementia unit dining room. Meals are plated and served thourgh this servery hatch. The cooks diary is a record of meals served and any menu or resident changes. Food temperatures are taken on the cooked food and on re-heating the tea meal. Fridge, freezer and chiller temperatures are recorded daily. All perishable foods are dated. Nutritional snacks are delivered to the dementia unit including fruit, sandwiches, sweet biscuits, crackers and toppings, muffins and puddings. Caregivers interviewed confirmed they have access to snacks, sandwiches, puddings and beverages in both the rest home and dementia unit. There is a kitchette area in the dementia unit and supplies of biscuits, sandwiches, fruit and snacks were sighted. The main kitchen area is equipped with oven/hobs, combi oven, fridges and freezers. The dry goods are sealed,labelled and stored off the floor. Goods are rotated weekly with the delivery of food orders. Safety data sheets are available and training provided as required. Chemicals are stored in a locked chemical cupboard. Personal protective equipment is readily available. There is a first aid kit in the kitchen. All equipment is checked regualrly and there is a maintenacne request book in the nurses station to log any non-urgent equipment concerns. The cleaning schedule is maintained as sighted.  The service receives feedback directly from the residents and from residents meetings. Residents interviewed (six rest home) are happy with the choice and variety of meals. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemicals supplies are locked in the shed on delivery. The owner monitors the chemical use and distributes to the kitchen, cleaning and laundry areas for use. Chemicals are stored safely in the laundry and kitchen areas. The chemical supplier supplies the chemicals, safety data sheets and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Staff have attended waste management and chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| E3.3e: There are quiet, low stimulus areas that provide privacy when required. E3.4.c: There is a safe and secure outside area that is easy to access. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and were reviewed. Medical equipment is calibrated annually. Hot water temperatures are checked monthly and records show that they are maintained in a safe range. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires on 1 May 2014. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located. The external areas are safely maintained and are appropriate to the resident groups and setting and include seating and shade. The secure outside area in the dementia unit has artificial grass for residents to walk on. The facility has chosen to use this as part of its falls management programme to minimise the risk of injury to residents should they sustain a fall. There is an aviary and guinea pigs located in the dementia unit garden. There are seating areas and umbrellas are used to provide shade.  The registered nurse and caregivers interviewed confirm that they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.  Residents interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs. ARC D15.3: The following equipment is available: shower chairs, one hoist and lifting aids. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents in the rest home and dementia unit. Hot water temperatures are monitored monthly. The toilets have appropriate access for residents based on their needs and abilities and facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet facilities have a system that indicates if it is engaged or vacant. There is also a safe locking system that provides for privacy but allows service providers access in the case of emergency. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Toilets and shower doors in the dementia unit have pictorial prompts to aid residents. There are two rest home resident rooms which are located on the ground floor. There is a toilet and bathroom located at that level for their use. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the residents to move about the room independently with the use of mobility aids. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed (six rest home) confirm their bedrooms are spacious and they can personalise them as desired. Relatives interviewed (three rest home and three dementia) state they are happy with the bedrooms. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The rest home has a large lounge and separate dining area. The dementia unit has a lounge and separate dining area. Small areas of the hallway carpet in the dementia unit were noted to be “rippled” but not enough to cause a trip or falls hazard. The service has identified that this is an area for improvement and the owner advised that she has been looking at alternative floor coverings as a replacement. D15.3d: Seating and space is arranged to allow both individual and group activities to occur. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander Adequate access is provided to lounge, dining and other communal areas and residents are able to move freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are cleaning and laundry policies and processes. Internal cleaning audits occur. There is a dirty and clean laundry entrance and dirty/clean work areas in the laundry. The laundry is spacious with washing, drying, folding and storage of linen areas. Adequate linen supplies were sighted. The laundry is well equipped with commercial washing machine, commercial dryers and a drying room. There is adequate ventilation in the laundry. Protective clothing is available including gloves, disposable aprons and face shield. There are designated locked cleaning cupboards. Spring cleaning of rooms is rotated. The cleaner’s trolley is well equipped and stored in a locked cupboard. An external supplier provides the chemicals, product use wall charts, conduct quality control checks and training as required. Interviews with six rest home residents state their personal clothing is laundered with care. Cleaning and laundry processes are monitored through the internal auditing programme and 2013 audits show satisfactory results. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.6: There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service and how the service will manage in a worst case scenario pandemic event. Interviews with the caregiver and enrolled nurse confirm staff are aware of emergency and security procedures. Fire training and security situations are part of orientation of new staff and the last emergency drill has been in 20 August 2013.  A fire services company conducts monthly checks. (Records sighted). All staff have a current first aid certificates as sighted employee files and training/education records reviewed. An approved evacuation scheme was signed off by the New Zealand Fire Service on 2 July 2004.  Extra blankets are available. There is emergency lighting at the facility and torches and batteries are stored (sighted). There is a gas BBQ and adequate stored water. There is at least three days’ supply of food.  Residents' rooms, communal bathrooms and living areas all have call bells. All staff are aware of the emergency process. This was confirmed at interviews with the registered nurse and caregivers. Rest home residents are orientated to the call bell system on admission to the facility. Security policies and procedures are documented and implemented by staff. Afternoon and night staff ensure all outside doors and windows are securely locked. There is security lighting for after dark. All staff interviewed are familiar with security measures. There is "swipe card” access by staff to the dementia unit. The garden area in the dementia unit has a key pad lock on the gates at both ends of the garden. The safety glazed panels that secure the dementia unit gardens have a special coating that allow the residents to see the views of the harbour but prevent visitors from seeing in. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated appropriately and maintained at a comfortable temperature. Heat pumps provide heating and air conditioning. Residents (six rest home) and relatives (three rest home and three dementia care) interviewed confirm the environment and the bedrooms are warm and comfortable. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit days. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint minimisation policies reviewed February 2013. There is one rest home level resident in the dementia unit so he can share a room with his wife. The DHB is aware of this. The resident was interviewed and has a swipe card to leave the unit so he is not considered to be environmentally restrained.  Staff education on RMSP /Enabler use was conducted in October 2011 and is planned for November 2013. Challenging behaviour management and de-escalation techniques training was provided in March 2013. Restraint use and review is part of the monthly management meeting.  E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour (with exceptions – refer finding # 1.3.5). |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Applicable |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Harbour View rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical coordinator is the designated infection control nurse with support from the registered nurses. There is a monthly staff meeting which incorporates infection control and health and safety and includes discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. The infection control programme has been reviewed by the clinical coordinator and manager in June 2013. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical coordinator at Harbour View is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains practice by attending annual infection control updates (last attended a training session on outbreak management and new infection definitions in May 2013). The IC nurse and IC team (comprising the management team and care staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is are infection control policy and procedures appropriate to for the size and complexity of the service. D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were initially developed by an external provider and have been reviewed and updated annually. The infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; surveillance, antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse who provides the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training annually - last session in May 2013. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education on hand hygiene and infection control provided for staff in April 2013 and June 2013. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly management meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/manager. On review of surveillance data and on discussion with RN’s, there have been no reports of infectious outbreaks. Infection suveillance data is gathered as per standard definitions for infections. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |