# Bainlea House (2013) Limited

## Current Status: 18 November 2013

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Bainlea House (2013) Ltd provides rest home and hospital level care for up to 57 residents at Bainswood Home and Hospital and dementia specific care for up to 28 residents at Bainlea House in Rangiora. On the days of the audit, there were 55 residents at Bainswood (19 at rest home level and 36 at hospital level) and 28 residents at Bainlea House dementia unit.

The rest home and hospital is managed by an experienced aged care manager with support from a nursing support manager. The dementia unit is also managed by an experienced aged care nurse manager. The services are owned and operated by two general managers/owners who purchased the facilities in July 2013. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed seven of the eight shortfalls from their previous provisional audit relating to communication with staff around audit outcomes, job descriptions, documentation, registered nurse input into progress notes, care plans reflect all identified needs, food temperatures are monitored, safe food handling training, calibration of equipment and time frames.

Further improvement continues to be required relating to completion of risk assessments for identified issues.

This surveillance audit identified that improvements are required relating to updating and maintaining a complaints register, and aspects of medication management.

## Audit Summary as at 18 November 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 |

| Indicator | Description | Definition |
|---|---|---|
| | 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 18 November 2013**

| | | |
|---|---|---|
| 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 18 November 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. | | Standards applicable to this service fully attained. |

**Continuum of Service Delivery as at 18 November 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 18 November 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 18 November 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 18 November 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. |

# 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

| | |
|---|---|
| **Legal entity name:** | Bainlea House (2013) Ltd |
| **Certificate name:** | Bainswood Home and Hospital and Bainlea House |

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

| | |
|---|---|
| **Types of audit:** | Surveillance |
| **Premises audited:** | Bainswood Home and Hospital and Bainlea House, Rangiora |
| **Services audited:** | Rest home, Hospital and Dementia |
| **Dates of audit:** | **Start date:** 18 November 2013 **End date:** 19 November 2013 |

| **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:** | 83 |

## 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

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

| | | | | | |
|---|---|---|---|---|---|
| Number of residents interviewed | 7 | Number of staff interviewed | 12 | Number of managers interviewed | 5 |
| Number of residents' records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 5 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 90 | Number of relatives interviewed | 10 |
| Number of residents' records reviewed using tracer methodology | 3 | | | Number of GPs interviewed | 2 |

# Declaration

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

I confirm that:

| | | |
|---|---|---|
| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| 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, 9 December 2013

# Executive Summary of Audit

| General Overview |
| --- |
| Bainlea House (2013) Ltd provides rest home and hospital level care for up to 57 residents at Bainswood Home and Hospital and dementia specific care for up to 28 residents at Bainlea House in Rangiora. On the days of the audit, there were 55 residents at Bainswood (19 at rest home level and 36 at hospital level) and 28 residents at Bainlea House dementia unit.<br>The rest home and hospital is managed by an experienced aged care manager with support from a nursing support manager. The dementia unit is also managed by an experienced aged care nurse manager. The services are owned and operated by two general managers/owners who purchased the facilities in July 2013. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.<br><br>The service has addressed seven of the eight shortfalls from their previous provisional audit relating to communication with staff around audit outcomes, job descriptions, documentation, registered nurse input into progress notes, care plans reflect all identified needs, food temperatures are monitored, safe food handling training, calibration of equipment and time frames.<br><br>Further improvement continues to be required relating to completion of risk assessments for identified issues.<br><br>This surveillance audit identified that improvements are required relating to updating and maintaining a complaints register, and aspects of medication management. |

| Outcome 1.1: Consumer Rights |
| --- |
| Bainlea House (dementia unit) and Bainswood on Victoria (rest home and hospital) provide care and support that focuses on the individual with residents and relatives praising the services provided. Family state that they are informed of any incidents. Complaints processes are implemented and complaints and concerns are actively managed. An improvement is required relating to documentation of a current complaints register. |

| Outcome 1.2: Organisational Management |
| --- |
| The general managers/owners are on site daily and have nine years of experience in owning aged care facilities. There is a nurse manager on each site and a nursing support manager at Bainswood on Victoria and they work closely together to provide operational management, all with extensive experience in aged care. There is a registered nurse on each shift in the hospital/rest home area and staff complete the orientation programme and training as per the annual plan. Staff in the dementia unit have completed or are training in dementia care.<br>The service has a quality and risk management programme implemented. The general manager/owner is currently reviewing policies and procedures and quality data is collected and evaluated and used for quality improvement. This includes incidents/accidents; hazards; internal audits; infections; complaints and concerns; and resident/family satisfaction surveys. An internal audit schedule is implemented.<br>Improvements required at the previous audit around corrective action plans and evidence of resolution, job descriptions and signing of progress notes have been addressed. |

**Outcome 1.3: Continuum of Service Delivery**

Bainswood on Victoria and Bainlea House have implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning, care plan evaluations and that the interventions noted in the care plans are consistent with meeting residents' needs.
A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. The previous provisional audit identified that risk assessments were not completed in a timely manner, improvement continues to be required in relation to one resident with identified behaviours.
Further shortfalls from theprevious audit around service deleivary have been addressed.
Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.
There is an appropriate medicine management system in place. Areas identified for improvement include ensuring that all medication given is prescribed, and all administration signing sheets and medicine records are completed.
Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis.

**Outcome 1.4: Safe and Appropriate Environment**

The facility is purpose built. All building and plant have been built to comply to legislation. The service displays a current building warrant of fitness for both facilities.Previous provisional audit findings relating to calibration and servicing of scales and lifting equipment has been addressed.

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

The dementia service has a restraint free philosophy and there are no restraints or enablers used in Bainlea House.
The use of restraints and enablers has decreased since May 2013 with the addition of new ultra low beds. There are two enablers used in the rest home/hospital service and seven identified restraints (bedrails) at Bainswood on Victoria.
All staff have had training around management of challenging behaviours on both sites.

**Outcome 3: Infection Prevention and Control**

Infection control policies and procedures are documented. The infection control co-ordinator (registered nurse/nurse manager at each site) is responsible for implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery.

## Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|---|---|---|---|---|---|---|---|
| **Standards** | 0 | 15 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 2 | 1 | 0 | 0 |

| | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|---|---|---|---|---|---|---|---|---|
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58 |

## Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The complaints register has not been updated with complaints since the new owners came on board in July 2013. | Update the complaints register to reflect any complaints and actions taken. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| HDS(C)S.2008 | Criterion 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. | PA Low | One of seven resident files reviewed (one rest home resident) did not have a behaviour assessments completed where there are identified behavioural issues. The long term care plan describes issues with anxiety and agitation and progress notes record frequent use of call bell. These issues relate to anxiety around an indwelling catheter and increased confusion. No behaviour assessment has been conducted. The resident has been referred to psychiatric services for the elderly for reassessment. | Ensure all care plans are based on the completion of appropriate assessments conducted for identified issues | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | a) Progress notes entry for one rest home resident, recorded by RN that the resident was noted to have oral thrush. The RN commenced a short term care plan for mouth cares and oral thrush medication treatment. Oral thrush medication (Mycostatin) is not listed on the standing order medications and no verbal order from GP was obtained until the day of audit. The order from the RN is recorded on the administration signing sheet. B) Gaps in signing of medication administered noted in five of 12 medication charts reviewed and included pre-packed medications and insulin injections. | a) ensure all medication administered to residents is prescribed by a GP and recorded on the medication chart; b) ensure all medication administered to residents is appropriately recorded and documented at the time of administration. | 30 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

#### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **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:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **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:** | Not Audited |
| **Evidence:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** | Not Audited |
| **Evidence:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)
Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARHSS D16.5e

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>There is a policy around open disclosure. There is an interpreter policy which includes references to resources.<br>Contact with family members following an incident is recorded on the accident/incident form (documented in all of the 18 incident forms reviewed) and in resident files reviewed. In addition, contact with the family is recorded in the progress notes with a stamp highlighting the communication.<br>Six caregivers interviewed (four hospital / rest home and two dementia unit); the two nurse managers and the registered nurse interviewed confirm that family are informed of any resident accidents or incidents.<br>There are no residents currently requiring interpreting services.<br>D16.4b 10 of 10 family members including four hospital, one rest home and five dementia confirm that there is good communication with the service and all state that they are informed of any incidents.<br>Residents interviewed (two hospital and five rest home) confirm that they are communicated with well.<br>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.<br>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 are not covered by the agreement.<br>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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)
Wherever necessary and reasonably practicable, interpreter services are provided.

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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 1.1.10: 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:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **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 1.1.11: 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:** | Not Audited |
| **Evidence:** | |

### 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:** | Not Audited |
| **Evidence:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

| **Attainment and Risk:** PA Low |
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| **Evidence:**<br><br>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained until April/May 2013 and shows investigation of all complaints, dates and actions taken for resolution.<br>There are two complaints documented since the new owners have taken over on 1/7/13 (one written and one verbal complaint). These were tracked for monitoring purposes to ensure that they are actioned according to timeframes, and identify when a complaint is resolved and this indicates that there has been resolution in a timely manner with both complainants stating that the response is satisfactory. These are not yet documented on a register.<br><br>D13.3h. A complaints procedure is provided to residents within the information pack at entry.<br>E4.1biii. 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 minimising restraint (no use of restraint in the dementia unit), behaviour management and implementation of the complaints policy.<br><br>10 of 10 family members including four hospital, one rest home and five dementia and residents interviewed (two hospital and five rest home) confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved.<br>One family member has raised a number of concerns about a family members care (same concerns raised in each email). The concerns are kept in the resident file and there are emails back to the family member from the service and the GP stating what actions have been taken. The concerns are not documented on the complaints register.<br>A complaint in August 2012 (previous owner) with the Health and Disability Commission has been closed out by the Commission in May 2013.<br>An improvement is required to the complaints register. |

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

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

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

### Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)
An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

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| **Attainment and Risk:** PA Low |
| **Evidence:**<br><br>There is a complaints register for the facility prior to the new owners took ownership in July 2013. There are also complaints kept in the quality folder that evidence resolution of issues. |
| **Finding:**<br><br>The complaints register has not been updated with complaints since the new owners came on board in July 2013. |
| **Corrective Action:**<br><br>Update the complaints register to reflect any complaints and actions taken. |
| **Timeframe (days):** 90 *(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:**<br><br>Bainlea House provides dementia level care to 28 of 28 residents and Bainswood on Victoria provides care for up to 57 residents (currently 55 residents including 19 rest home and 36 hospital residents. All beds in Bainswood on Victoria are swing beds.<br>There is an overall business plan and risk management plan for another premise owned by the general managers/owners and the intention is to review this and align to meet the needs of the two sites. The general managers/owners are putting this in place slowly as they have had to address issues left from the previous owners (identified in the issues based audit and provisional audit).<br>The provider's mission statement is to provide quality health care and services to North Canterbury and the wider district. The provider's philosophy of care states that "We believe that: an environment will be provided which allows a resident to live as a continuance of their life before admission within the limitations of their health needs. Each resident will have the choice and involvement in decision making concerning their care and in the environment around them. The ongoing involvement of family/whanau is integral to the resident's wellbeing. A resident will feel at home within an atmosphere of security, tranquillity and care."<br><br>ARC E2.1. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.<br><br>The general managers/ owners have owned/managed rest homes for the past nine years. One owner has a background in diversional therapy and one as a policeman. |

The general managers/owners provide oversight to both Bainlea House and Bainswood on Victoria with nurse managers on each site.
The nurse manager for Bainlea House (registered nurse) has been in the role for four years and has extensive experience in aged care including mental health and dementia units. The nurse manager in Bainswood on Victoria (registered nurse) has been with the service for a year having been brought in after an issues based audit. She has extensive experience in aged care as a clinical nurse manager including working in other facilities.
D17.3di (rest home) & D17.4b (hospital): The managers have maintained at least eight hours annually of professional development activities related to managing a dementia unit, rest home and/or hospital.

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

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

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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.)* |

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

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>Bainswood on Victoria and Bainlea House have a documented quality and risk management system that is overseen by the general managers/owners with onsite direction and leadership from the nurse managers at both sites.<br>Discussions with the registered nurse, two nurse managers and the nursing support manager as well as the six caregivers and review of meeting minutes demonstrates staff involvement in quality and risk activities. The monthly quality improvement, health and safety and infection control meeting is held at each site and all staff are asked to attend. There is a bi-monthly caregiver meeting at Bainswood on Victoria with meetings held for AM, PM and night staff and a caregiver meeting at Bainlea House each month with it being offered on a different shift each month. There is a bi-monthly registered nurse/enrolled nurse meeting at Bainswood on Victoria. Meeting minutes |

indicate that the meetings have been introduced since the general managers/owners took over in July 2013. Minutes are documented and indicate that meetings are held as planned. There is a management meeting to be held in the next three days and the general manager/owner states that these will become regular.
Resident meetings are held two to three monthly at Bainswood on Victoria with rest home and hospital combined and family meetings are held three times a year at Bainlea House. Minutes are documented.
Annual resident and relative surveys are undertaken with the last collated in December 2012 under the old management team.
D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements and the owner/general manager is reviewing these to align with the system already implemented at another site.
The quality and risk system is documented and links with associated policies/procedures. Clinical policies and procedures are in place for the rest home, dementia unit and hospital. While the current policies have the name of the previous owners, the intention is to change these as each policy is reviewed.
There is a document control process implemented that includes a review date and sign off by the general managers/owners.
D19.3 There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the quality improvement, health and safety and infection control monthly meetings. A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings.
D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.
D19.2g Falls prevention strategies such as the purchasing of ultra hi/lo beds, staff supervision and a review of any incidents around falls are implemented. The purchase of ultra low beds has reduced the use of restraint (bedrails) and staff state that the number of falls from residents has decreased.
Staff interviewed including the six care givers (four rest home/hospital and two dementia) state that being involved in the quality programme has given them an opportunity to identify any issues, discuss quality and to make suggestions.
The owners have purchased new equipment for staff and staff state that they are more supported by the general managers/owners more than ever before.
The general managers/owners are in the process of changing all documentation to the new name.
There is an implemented internal audit programme and all audits identify corrective actions required and these are documented with sign off of resolution in a timely manner. Discussion of audits and any corrective actions occurs through the quality, health and safety and infection control meetings held regularly and the minutes are left in the staff room/office at both sites (sighted). The improvement required at the previous audit has been addressed and monitored.

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

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

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

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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.)* |

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

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

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

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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.)* |

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

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

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

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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.)* |

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

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

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

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

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

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

| **Attainment and Risk:** FA |
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| **Evidence:**<br><br>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.<br>The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the Ministry of Health.<br>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.<br>Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.<br>Meeting minutes from the quality improvement, health and safety and infection control meetings reflect discussions of incidents/accidents and actions taken.<br>A review of incident/accident forms for Bainlea House (eight) and Bainswood on Victoria (10 reviewed) identifies that all 18 incident forms are fully completed and include follow-up actions taken.<br>The general managers/owners state that they have notified HealthCERT and the DHB of the change in ownership (sighted documentation). |

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

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

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

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

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

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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 1.2.7: 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:** FA |
| **Evidence:**<br><br>A register of registered nurse, enrolled nurse, doctor, podiatrist, dietician, pharmacist practising certificates are kept within the facility indicating that all relevant staff have a current annual practising certificates.<br>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one registered nurse, three caregivers, one cleaner, one nurse manager) include relevant induction books, referee checks, training, and development records.<br>Bainlea House and Bainswood on Victoria have in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each site noting that both programmes include management of challenging behaviour and care of residents with dementia.<br><br>E4.5f There is a training programme at each site and 13 of the 15 caregivers who work in the dementia unit have completed their dementia qualifications. Two others are enrolled. The activities coordinator has completed the dementia training and is now enrolled in the diversional therapy training. Other staff in Bainswood on Victoria have also completed the dementia training.<br><br>There is an implemented education plan (sighted for 2013) for each site and this is well implemented. The annual training programme well exceeds eight hours annually. Annual formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification and all six files reviewed include a current performance appraisal.<br><br>D17.7d: There are implemented competencies for staff relating to specialised procedures or treatment including medication competency (refer 1.3.12), restraint competency and syringe driver competency.<br>Registered nurses are supported to maintain their professional competency. Employee training records are maintained. |

E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.
E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency noting that the dementia unit uses staff from Bainswood on Victoria who have completed the dementia standard training (confirmed by one caregiver interviewed).
Six of six staff files include a signed job description. The improvement required at the previous audit around job descriptions on staff files has been addressed.

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

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

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

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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.)* |

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

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

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

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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 1.2.8: 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:**<br>There is good employer policy which includes staffing levels and skills mix. There is registered nurse cover 24/7 in the rest home and hospital. The dementia unit after hours on call cover is provided by the nurse manager and the nurse manager/nursing support manager from the rest home/hospital cover Bainswood on Victoria.<br>There are two facilities that are on separate sites - Bainswood on Victoria (hospital and rest home) has a full time nurse manager, a full time nursing support manager and |

24/7 RN cover. The Bainlea House dementia unit has a nurse manager who works 40 hours per week and provides on-call cover. There is an enrolled nurse who works in the rest home/hospital three days a week.
Staffing has been increased in the rest home and hospital and dementia unit by the new general managers/owners who are advertising for more cover currently. Staffing is as follows;
Bainswood on Victoria: AM – five full shifts, four short shifts with another pending appointment; PM: four full shifts and three short shifts with a kitchen assistant as well; night: three caregivers.
Bainlea House: Weekend - AM – three full shifts; PM – two full and one short shift; night – two full shifts. In the week days AM- one full and two short shifts; PM – two full shifts, one kitchen assistant, one short shift; night – two caregivers.
Residents interviewed (two hospital and five rest home) and 10 of 10 family members including four hospital, one rest home and five dementia confirm that staffing numbers are adequate to meet the resident's needs. Six caregivers interviewed (four hospital / rest home and two dementia unit); the two nurse managers and the registered nurse interviewed confirm that staffing ratio to residents is adequate, and that the adjustment of staffing with the introduction of more staff on each shift at both sites has improved work systems.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>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 support plan is also developed in this time.<br>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration.<br>D7.1 Entries are legible, dated and signed by the relevant caregiver, registered or enrolled nurse. A review of progress note in seven of seven files indicates that |

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| designation of the staff member is recorded on written entry and all entries are legible. The improvement required at the previous audit has been met. |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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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.)* |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARHSS D4.2

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **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

**Attainment and Risk:** PA Low

**Evidence:**

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. Seven files were reviewed (two rest home, two hospital and three dementia). Seven of seven long term care plans were completed within the three week time frame and appropriate assessments have been completed for all identified issues with the exception of one rest home resident file.
Wound care assessments and treatment plans were reviewed and included eight hospital residents and two dementia residents. Wounds included three pressure areas on sacrum, four skin tears, one chronic ulcer and one in-grown toenail. Activity assessments and activities care plans have been completed by the activity staff.
Staff are familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool is not currently in use, however, one registered nurse in the hospital area has completed InterRAI training and further RN staff are enrolled to start in 2014.

D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluations are completed within six months.
D16.5e; Medical assessments were documented in seven of seven long term files reviewed within 48 hours of admission. Three monthly medical reviews were documented in all seven files by a general practitioner. It was noted in all seven resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring more frequent care.
Assessment tools available for completion on admission include a) pressure area risk assessment, b) pain assessment and pain charts, c) disturbing behaviours assessment and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly. Behaviour assessment for one rest home resident has not been conducted. This remains a finding from the previous audit and improvements are required in this area.

Staff could describe a verbal handover at the end of each duty (also observed in the dementia unit) that maintains a continuity of service delivery. GP's from two medical practices in Rangiora provide the service with visits to residents. On interview, the two GP's interviewed advised that one visits the rest home and hospital facility and the other visits the dementia unit – at least weekly. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Seven files reviewed evidence this is occurring. This is an improvement from the previous audit. A physiotherapist is contracted to visit weekly and conducted mobility and transfer assessments. Both GP's interviewed stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.

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

Tracer Methodology: Rest Home resident
XXXXXX *This information has been deleted as it is specific to the health care of a resident*

Tracer Methodology: Dementia resident

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:**<br>On review of seven long term care plans (two rest home, two hospital and three dementia) all seven care plans have interventions recorded for identified goals and issues. Aspects of the long term care plan include (but are not limited to) mobility, continence, activities of daily living, dietary needs, pain management, communication/sensory, behaviour management, spiritual/cultural/social, skin and wounds.<br>Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health. There is evidence that residents are seen by their GP at least three monthly and within 48 hours of admission in seven of seven files sampled. The care plan format is comprehensive and goal oriented. Six of seven care plans reviewed record a plan of care which is based on comprehensive assessments. |
| **Finding:**<br>One of seven resident files reviewed (one rest home resident) did not have a behaviour assessments completed where there are identified behavioural issues. The long term care plan describes issues with anxiety and agitation and progress notes record frequent use of call bell. These issues relate to anxiety around an indwelling catheter and increased confusion. No behaviour assessment has been conducted. The resident has been referred to psychiatric services for the elderly for reassessment. |
| **Corrective Action:**<br>Ensure all care plans are based on the completion of appropriate assessments conducted for identified issues |
| **Timeframe (days):** 90 *(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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **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 1.3.5: Planning (HDS(C)S.2008:1.3.5)

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

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

**Attainment and Risk:** FA

**Evidence:**

Previous audit finding identified that two of nine care plans sampled did not have interventions that correlate to identify needs (#1.3.5.2). On review of seven long term care plans (two rest home, two hospital and three dementia) all seven care plans have interventions recorded for identified goals and issues. Aspects of the long term care plan include (but are not limited to) mobility, continence, activities of daily living, dietary needs, pain management, communication/sensory, behaviour management, spiritual/cultural/social, skin and wounds.
Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health. There is evidence that residents are seen by their GP at least three monthly and within 48 hours of admission in seven of seven files sampled. The care plan format is comprehensive and goal oriented. Seven of seven care plans reviewed record a plan of care which is based on comprehensive assessments. This is an improvement from previous audit. One of seven (one rest home resident) did not have a behaviour risk assessments completed where there are identified issues. (link #1.3.3.3)
D16.3k: Short term care plans are in use for changes in health status. Residents' files evidenced a short term care plan in use for pain, skin rash, and behaviour management. Infections, wounds, increased need for insulin, weight loss and decreased mobility.

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

### Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>Seven resident files were reviewed and included two rest home, two hospital and three dementia residents.<br>Residents care plans are completed by registered nurses. Care delivery is recorded and evaluated by caregivers and/or registered nurses at least daily (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. GP documentation is kept in the resident's file. Interviews with six caregivers (four from the hospital and rest home and two from the dementia unit), one registered nurse (from the hospital and rest home), one enrolled nurse (from the hospital and rest home), one nurse manager and one nursing support manager (from the rest home/hospital) and one nurse manager (from the dementia unit) indicate that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies, hoists and any miscellaneous items. Seven of seven residents (five rest home and two hospital) interviewed and ten of ten relatives (one from the rest home, four from the hospital and five from the dementia unit) interviewed were complimentary of care received at the facility.<br>Each resident has a long term care plan that includes; problem/need, objectives, interventions, evaluation for identified issues. The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives for seven of seven files reviewed. There were short term care plans for infections, wounds, skin tears, pain management, and changes in health status, skin conditions, behavioural issues and return from acute care. Residents with wounds demonstrate a link between short term care planning and wound management plans.<br>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use in the rest home area (Victoria wing), hospital area (Ivory wing) and in Bainlea House dementia unit.<br>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-services held in February 2013 for rest home/hospital and Dementia unit, and wound management in-service have been provided in March 2013 for both units.
Wound assessment and wound management plans are in place for eight hospital residents and two dementia unit residents. The registered nurses and enrolled nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.
One hospital resident has input from district nursing wound specialist.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two activities coordinators at Bainswood on Victoria (rest home and hospital service level) and one activities coordinator at Bainlea House dementia unit. The activities staff at the rest home/hospital provide up to 50 hours per week of activities and at the dementia unit the activities coordinator works 26 hours per week. All three staff are working towards completing their diversional therapy training. The dementia unit activities coordinator has completed the dementia unit standards qualification. The programme for each unit is planned monthly and residents in the rest home/hospital receive a personal copy of planned monthly activities. Activities planned for the day are displayed on notice boards around the facility at the rest home/hospital.<br>A social profile is completed on admission which forms the basis for the activities plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes all activities documentation. The programme is evaluated and can be individually tailored according to resident's needs.<br>Two activities staff interviewed (one rest home/hospital and one dementia unit) advised that residents are able to participate in community activities as well as activities in the service itself. |

Activities in the rest home/hospital include (but not limited to): exercises, newspaper reading, housie, ladies group, cross words, cards, entertainment, happy hour, games, bowls, darts, concerts, church services, craft, outings, movies, musical groups, school group visits and seasonal celebrations.
Activities in the dementia unit include (but not limited to): exercises, newspaper reading, ball games, puzzles, seasonal functions, walks, movies, cooking, crafts, massage, pet therapy, church services, games, reminiscing, ball games, and entertainment. Caregivers have access to activities and diversional therapy boxes and items for use after hours and in weekends.
All seven residents (five rest home, two hospital) and 10 family members (one rest home, four hospital, five dementia) interviewed discussed enjoyment in the programme and the diversity offered to all residents.
D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

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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 1.3.8: 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:** FA |
| **Evidence:** |

Six of seven long term care plans reviewed evidenced that the entire care plan evaluations are comprehensive, relate to each aspect of the care plan and record the degree of achievement of goals and interventions. One of seven care plans reviewed has been developed within the past six months and is therefore not yet due for formal evaluation. Care plans reviewed are updated as changes are noted in care requirements. Short term care plans are well utilised for rest home, hospital and dementia residents. Any changes to the long term care plan are dated and signed. Seven of seven care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan.
Short term care plans were sighted for wounds, pain management, behaviour management, skin rash, infections and short term health issues.
D16.4a Care plans are evaluated six monthly more frequently when clinically indicated
D16.3c: All initial care plans were developed with 24 hours of admission and 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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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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 1.3.9: 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:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:**<br><br>The service uses individualised medication blister packs provided from a medication management service. The medications are delivered monthly and checked in by two staff – one being a registered nurse. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications.<br>A registered nurse and an enrolled nurse were observed administering medications to the rest home/hospital residents, and a senior caregiver was observed administering medications to the dementia unit residents. All three staff followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in locked treatment room in the rest home area and the hospital area and in the locked nurse's station in the dementia unit. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. On review of one of 12 medication charts is it noted that a registered nurse has initiated oral thrush medication for one rest home resident which is not a standing order medication and no verbal order was received from the GP prior to commencing the treatment. A written order from the GP was obtained on the day of audit. Improvement is required in this area.<br>Controlled drugs are stored in two locked safes inside two locked treatment rooms in the Bainswood on Victoria rest home/hospital facility. The dementia unit has a locked safe in the nurse's station at Bainlea dementia unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. Medication fridge's are monitored daily and recorded weekly.<br>Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 12 drug charts reviewed. Allergies or nil known allergies are recorded on 12 of 12 medication charts reviewed. It is noted that there were gaps in signing sheets for administration of medications for five of 12 resident medication charts reviewed including pre-packed medications and insulin doses. Improvements are required in this area. |

An annual medication administration competency is completed for all registered nurses, enrolled nurses and senior care givers. Advised that all staff administering medication must attend compulsory training. Medication training conducted for both facility staff in May 2013. Competencies for all staff with medication administration responsibilities were reviewed. There is a self-medicating resident's policy in place. A self-medication assessment checklist is available. There is currently one rest home resident who self-administer inhaler medications. Appropriate competency assessment has been completed. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. PRN medication orders all record indications for use.
D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by two staff – one being a registered nurse. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications.
A registered nurse and an enrolled nurse were observed administering medications to the rest home/hospital residents, and a senior caregiver was observed administering medications to the dementia unit residents. All three staff followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in locked treatment room in the rest home area and the hospital area and in the locked nurses' station in the dementia unit. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

**Finding:**

a) Progress notes entry for one rest home resident dated 16-Nov-13. Recorded by RN that the resident was noted to have oral thrush. The RN commenced a short term care plan for mouth cares and oral thrush medication treatment. Oral thrush medication (Mycostatin) is not listed on the standing order medications and no verbal order from GP was obtained until the day of audit. The order from the RN is recorded on the administration signing sheet.
B) Gaps in signing of medication administered noted in five of 12 medication charts reviewed and included pre-packed medications and insulin injections.

**Corrective Action:**

a) ensure all medication administered to residents is prescribed by a GP and recorded on the medication chart; b) ensure all medication administered to residents is appropriately recorded and documented at the time of administration.

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

### Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

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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.)* |

### 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:** |
| **Finding:** |

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All kitchen staff have now completed Food Safety Certificates (NZQA). This is an improvement from previous audit. The service has a modest sized kitchen in the rest home/ hospital area that contains a large fridge, a freezer and a pantry, large cooker and cook tops, dishwasher, servery and sink. The menu is designed and reviewed by a Registered Dietitian (last conducted May 2013). There is a four weekly winter and summer menu. Feedback from residents and families interviewed was positive. All meals for rest home and hospital residents are cooked in the main kitchen at Bainswood and are served to residents in the adjoining dining room and on trays to the hospital residents in Ivory wing. Staff were observed wearing head covering and gloves while serving food. Staff were observed assisting residents with their lunch time meals and drinks.
Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. There is a food service manual and cleaning schedules. Food in fridges, freezer and pantry are labelled and dated. Decanted food is dated and time for rotation is recorded. Cleaning schedules are implemented. Meals for residents in the Bainlea dementia unit are provided and transported from a neighbouring rest home (same ownership). Food temperatures are recorded for all hot and cold dishes prior to serving at the rest home/hospital and at the dementia unit. Monitoring records were sighted. Bain maries are used to keep food hot prior to serving. This is an improvement from the previous audit.
Nutritional assessments are conducted on all residents and the kitchen staff are informed of dietary requirements. Residents with special dietary needs are catered for. Nutritional assessments are reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the whiteboards which are able to be viewed only by kitchen staff.
D19.2 staff have been trained in safe food handling.
E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours at Bainlea House dementia unit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

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

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

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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.)* |

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

# Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service is over two sites. Bainswood on Victoria rest home and hospital has two wings - Ivory wing with 27 beds and Victoria wing with 30 beds. Both wings are spacious and well maintained and provide rest home and hospital level care. Bainlea House is at a separate address and is a 28 bed secure dementia unit.
There is a current building warrant of fitness at each facility with Bainswood Home and Hospital expiring on 1 February 2014 and Bainlea House expiring on 20 June 2014. There are systems in place to ensure the residents' physical environment and facilities are fit for their purpose at both sites. Planned and reactive maintenance systems are in place and were reviewed. At Bainswood on Victoria the wheelchair scales were calibrated in October 2013. At Bainlea House the scales were checked and calibrated on 13 June 2013 – this is an improvement from the previous audit. Hot water temperatures are checked monthly and records show that they are maintained in a safe range.
A visual Inspection of the facility provides evidence of the safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely and safety rails are secure and appropriately located. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.
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, three hoists (at the home and hospital) and lifting aids, pressure relieving mattresses, sensor mats, wheelchairs.
E3.4d: The lounge area at Bainlea House is designed so that space and seating arrangements provide for individual and group activities.
E3.3e: There are quiet, low stimulus areas that provide privacy when required.
E3.4.c: There is a safe and secure outside area at Bainlea House that is easy to access.

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

### Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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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.)* |

### 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:** |
| **Finding:** |

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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 manoeuvre with the assistance of their aid within their personal space/bed area.

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARC E3.4b ARHSS D15.3d

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)
Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e  ARHSS D15.2c; D15.2d; D19.2e

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation plan.

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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| **Attainment and Risk:** Not Audited |
| **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.)* |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARC D15.2f ARHSS D15.2g

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br><br>The policy around restraint and enablers is applicable to the type and size of the service (rest home, hospital and dementia unit). Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, including definitions, processes and use of enablers.<br>The policy includes that enablers are voluntary and the least restrictive option. There are two enablers (bedrails) in use and seven restraints (bedrails, one with a bedrail and fallout chair and one with a bedrail and lap belt when necessary noting that this has not been used to date). The one enabler file (rest home level) was reviewed and included consents and an assessment.<br>Strategies are in place to minimise the use of restraint including ultra lo beds, mobility aids and supervision of residents.<br>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.<br>Staff have had training around challenging behaviours, restraint and enablers at Bainswood on Victoria and in Bainlea House last in February 2013.<br>Six caregivers interviewed (four hospital / rest home and two dementia unit); the two nurse managers and the registered nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours.<br>The use of restraint has decreased at Bainswood on Victoria with 14 in use in May 2013 and currently seven now in use. The purchase of ultra lo beds and an increase in staffing has served to decrease the use of restraint. |

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

# Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

Services use restraint safely

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

| |
|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Services evaluate all episodes of restraint.

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

| |
|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

| |
|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

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

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

| |
|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

ARC D5.4e ARHSS D5.4e

| |
|---|
| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **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 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:** Not Audited |
| **Evidence:** |

### 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:** Not Audited | |
| **Evidence:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |

### 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:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)
Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)
Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

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| **Attainment and Risk:** FA |
| **Evidence:**<br>The infection control surveillance policy describes the surveillance programme. The quality improvement, infection control and health and safety meeting meet monthly acts as the IC committee. A monthly infection summary report is completed. The surveillance includes a) systematic surveillance, b) response to surveillance activities, c) |

development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.
All infections are collected via the infection report form and are collected and discussed at the meetings. There is a collated report of infections monthly including site and use of antibiotics and a graph generated. The infection control data is now left with the minutes of the meetings in the staff room for staff to review. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.
The infection control coordinator is the nurse manager at each site. Infection control data is also discussed at registered nurse/enrolled nurse and caregiver meetings.
Internal audits are completed in 2013 as per schedule e.g. hand washing audit Sept 13, waste management Nov 2013, food hygiene June 2013, food service Jan 2013, equipment hygiene Aug 2013.
Staff interviewed including the caregivers, nurse managers, registered nurse and enrolled nurse confirm knowledge of best infection control practice and of surveillance data.

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

### Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| **Finding:** |
| **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.)* |