# Park Lane Retirement Village Limited

## Current Status: 11 November 2013

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

## General overview

Park Lane Retirement Village is a new purpose-built facility that has been in operation since January 2013. The Park Lane facility is modern, spacious and extends across three levels. There are 45 studio/serviced apartments across level one (ground level) and level three. Both floors can provide rest home level of care as required. Level two is a 42 bed care centre suitably designed to provide hospital or rest home level care. The design of each floor encourages resident independence and all resident rooms have single en-suites.

The facility is managed by an experienced husband and wife team that have owned a number of aged care facilities. The owner/operators report to a board of directors. An experienced aged care clinical nurse manager is employed full time to manage the care centre. All newly employed staff completed two weeks orientation/training prior to the facility opening. The care centre is fully occupied on the day of audit.

Residents and families interviewed were very complimentary about the environment, the management and staff, and the high standard of care and service received.

There are improvements required around incident documentation for one resident, outbreak reporting, aspects of care planning, and medication competency for two night staff.

## Audit Summary as at 11 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 |
|  | 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 11 November 2013

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

### Organisational Management as at 11 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 11 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 low risk. |

### Safe and Appropriate Environment as at 11 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 11 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 11 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. |

## Audit Results as at 11 November 2013

### Consumer Rights

Park Lane practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed in the care centre.

There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process.

There are implemented policies at Park Lane to protect residents from discrimination or harassment. Clinical policies are developed by an aged care consultant. There is a process in place to inform staff of policy change. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau.

### Organisational Management

The organisation has a three year business plan in place and annual quality objectives. The service has purchased healthcare compliance policies, procedures and quality processes and these have been implemented. Quality, health and safety and infection control are set agenda items at management and staff meetings. There is an improvement required around incident documentation for a resident that wanders and outbreak reporting.

Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal and external audits and receive meeting minutes. There is evidence open disclosure is practised. The service has comprehensive policies/procedures to provide rest home care, and hospital level care. All staff have completed a comprehensive orientation programme. There are documented job descriptions for all positions which detail each position’s responsibilities, accountabilities and authorities.

There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. There is a 2013 education planner in place that include compulsory training for aged care staff. There is an improvement required around medication competency for two night staff members.

### Continuum of Service Delivery

Park Lane Retirement Village has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery.

Resident and family interviews confirm their input into care planning, care evaluations and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that care provided is consistent with meeting their needs.

There is improvements required around aspects of assessments, short term care plans and wound documentation. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes.

Planned activities are appropriate to the group setting. Diversional Therapy care plans were evidenced to be comprehensive and reviewed six monthly. Residents and family interviewed confirm satisfaction with the activities programme stating the Diversional Therapist organises activities that are fun and entertaining.

An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities.

Food service is provided on site and kitchen staff have completed food safety training. Residents' individual dietary needs are identified, documented and reviewed on a regular basis.

### Safe and Appropriate Environment

The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. There is a current Certificate of Public Use (CPU) in place. The maintenance role includes checks for safety of the facility and implementing requests from the maintenance book. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. All rooms are single with ensuites. Sufficient shower and toilet facilities are available. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting. The residents interviewed were very complimentary of the laundry service provided.

### Restraint Minimisation and Safe Practice

The service meets the intent of the restraint standards. Restraint minimisation is discussed at the staff, quality and management meetings. There is a restraint co-ordinator with defined responsibilities. An approval group meets regularly. There are two residents with restraints in use. There are assessments, reviews, care plans, monitoring and restraint register in place.

### Infection Prevention and Control

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. The Infection Control team is part of the combined quality meeting. Reports and surveillance data are discussed at staff meetings. All staff received infection control education on orientation and attends education as offered. Hand hygiene competencies are completed.

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Park Lane Lifecare Ltd |
| **Certificate name:** | Park Lane Retirement Village |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand (HDANZ) |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | 35 Whiteleigh Avenue, Christchurch | | | |
| **Services audited:** | Medical, Geriatric and Rest Home services. | | | |
| **Dates of audit:** | **Start date:** | 11 November 2013 | **End date:** | 12 November 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 42 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 13 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 13 | **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** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 26 | Total audit hours off site | 13 | Total audit hours | 39 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 18 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 48 | Number of relatives interviewed | 7 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **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:

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

Dated Monday, 23 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Park Lane Retirement Village is a new purpose-built facility that has been in operation since January 2013. The Park Lane facility is modern, spacious and extends across three levels. There are 45 studio/serviced apartments across level one (ground level) and level three. Both floors can provide rest home level of care as required. Level two is a 42 bed care centre suitably designed to provide hospital or rest home level care. The design of each floor encourages resident independence and all resident rooms have single en-suites.  The facility is managed by an experienced husband and wife team that have owned a number of aged care facilities. The owner/operators report to a board of directors. An experienced aged care clinical nurse manager is employed full time to manage the care centre. All newly employed staff completed two weeks orientation/training prior to the facility opening. The care centre is fully occupied on the day of audit.  Residents and families interviewed were very complimentary about the environment, the management and staff, and the high standard of care and service received.  There is improvements required around incident documentation for one resident, outbreak reporting, aspects of care planning, and medication competency for two night staff. |

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| **Outcome 1.1: Consumer Rights** |
| Park Lane practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed in the care centre.  There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process.  There are implemented policies at Park Lane to protect residents from discrimination or harassment. Clinical policies are developed by an aged care consultant. There is a process in place to inform staff of policy change. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. |

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| **Outcome 1.2: Organisational Management** |
| The organisation has a three year business plan in place and annual quality objectives. The service has purchased healthcare compliance policies, procedures and quality processes and these have been implemented. Quality, health and safety and infection control are set agenda items at management and staff meetings. There is an improvement required around incident documentation for a resident that wanders and outbreak reporting. Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal and external audits and receive meeting minutes. There is evidence open disclosure is practised. The service has comprehensive policies/procedures to provide rest home care, and hospital level care. All staff have completed a comprehensive orientation programme. There are documented job descriptions for all positions which detail each position’s responsibilities, accountabilities and authorities.  There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. There is a 2013 education planner in place that include compulsory training for aged care staff. There is an improvement required around medication competency for two night staff members. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Park lane Retirement Village has documented entry criteria, which is communicated to residents, family and referral agencies. Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and is coordinated to promote continuity of service delivery.  Resident and family interviews confirm their input into care planning, care evaluations and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services demonstrate that consultation and liaison is occurring with other services and residents interviewed confirm that care provided is consistent with meeting their needs.  There is improvements required around aspects of assessments, short term care plans and wound documentation. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes.  Planned activities are appropriate to the group setting. Diversional Therapy care plans were evidenced to be comprehensive and reviewed six monthly. Residents and family interviewed confirm satisfaction with the activities programme stating the Diversional Therapist organises activities that are fun and entertaining.  An appropriate medicine management system is implemented. Policies and procedures record service provider responsibilities.  Food service is provided on site and kitchen staff have completed food safety training. Residents' individual dietary needs are identified, documented and reviewed on a regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has a policy for investigating, recording and reporting incidents involving infectious material or hazardous substances. Chemical safety training is provided to staff. There is a current Certificate of Public Use (CPU) in place. The maintenance role includes checks for safety of the facility and implementing requests from the maintenance book. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. All rooms are single with ensuites. Sufficient shower and toilet facilities are available. General living areas and resident rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. There are outside paved areas with suitable furniture and natural shading. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting. The residents interviewed were very complimentary of the laundry service provided. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service meets the intent of the restraint standards. Restraint minimisation is discussed at the staff, quality and management meetings. There is a restraint co-ordinator with defined responsibilities. An approval group meets regularly. There are two residents with restraints in use. There are assessments, reviews, care plans, monitoring and restraint register in place. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. The Infection Control team is part of the combined quality meeting. Reports and surveillance data are discussed at staff meetings. All staff received infection control education on orientation and attends education as offered. Hand hygiene competencies are completed. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 46 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 5 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | While the gastric outbreak was well contained and managed including input from the CDHB infection control nurse. Public Health were not notified of the gastric outbreak | Ensure the public health is notified of any outbreak as per policy | 60 |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | There was one incident form completed for a resident that wandered from the facility. While the long term care plan identified monitoring requirements, there was no documented evidence of identified monitoring post incident for this resident. | Ensure post incident monitoring is implemented as documented in the care plan. | 60 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There are two HCAs on night shift checking controlled drugs that have not undertaken a medication competency. Since the draft report the provider has confirmed these two staff members have completed a competency. | Ensure HCA’s checking controlled drugs undertake a medication competency | 60 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Assessment tools completed were not consistently signed and dated by the registered nurse completing the assessments. | Ensure completed assessments are signed and dated by a registered nurse. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i)Two of 16 wound management plans did not document the type of wound currently being treated. The Wound and Skin Care Register was not current- one resident with a diabetic foot ulcer was not included in the register and the register is not consistently updated when wounds are resolved. (ii) Interventions documented in STCPs were minimal e.g. administer antibiotics. (iii) STCPs were not consistently evaluated to evidence resolution or improvement/deterioration of condition. | (i)Ensure the type of wound being treated is documented on wound care management plans. Ensure the Wound and Skin Care Register is updated when wounds have healed and when new wounds are identified. (ii) Ensure STCPs are evaluated to monitor progress towards achieving desired goal. | 30 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Park Lane retirement village policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumer Rights. The service provides families and residents with a Welcome Pack on entry to the service and this information contains details relating to the code of rights, complaints process and advocacy.  Staff receive a comprehensive orientation that includes resident’s rights. There is on-going in-service training with a total of 29 staff attending Code of Rights in service in July 2013. Interviews with six health care assistants (HCAs), (one studio, and five rest home/hospital) showed an understanding of the key principles of the code of rights and are able to describe daily situations where a residents consent and choice is obtained. Residents interviewed (four rest home and four hospital) and relatives (three rest home and four hospital) confirmed that staff respected privacy, obtained consent as appropriate and offered choices. The Code of Rights is displayed at the entrance of the rest home/hospital unit. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a welcome information folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their advocate, enduring power of attorney or legal representative. There are on-going opportunities for discussion during care planning meetings, resident meetings and during other regular contact with family. Advocacy pamphlets are clearly displayed at the main facility entrance and rest home/hospital entrance. Code of rights, advocacy information on concerns/complaints is brought to the attention of residents and families at admission, in the welcome pack and at the two monthly resident meetings. Residents interviewed (four rest home and four hospital) and relatives (three rest home and four hospital) confirmed that information has been provided around the code of rights. The facility manager (Privacy Officer) has an open door policy for concerns or complaints.  D6.2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, complaints policy, code of rights, H&D Commission and advocacy pamphlet. The facility manager and clinical manager described discussing the information pack with residents/relatives on admission.  D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility provides physical, visual, auditory and personal privacy for residents. All bedrooms are single with ensuites. During the audit, staff were observed knocking on bedroom doors and gaining permission prior to entering resident rooms.  D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Residents are encouraged to personalise their bedrooms. Residents interviewed stated staff are respectful of their belongings.  D3.1b, d, f, i The service has a philosophy that promotes the highest standard of care, companionship, security and involves residents in decisions about their care, respects their rights and maintains privacy and individuality Resident preferences are identified during the admission and care planning process with resident/family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with six HCAs described providing choice during daily cares including shower times, settling times and choice of clothes to wear.  Interview with eight residents (four rest home and four hospital) all stated staff provided a respectful service and were very, caring, approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete compulsory education attended May 2013. Abuse and neglect training is included as part of the staff orientation programme. Discussions with residents and family members were positive about the care provided.  D4.1a Seven resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with resident/family involvement and is integrated with the residents' long term care plan. This includes cultural, religious, social and ethnic needs. Interviews with eight residents (four rest home and four hospital) confirmed that their values and beliefs are considered. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A3.2 There is a Maori health plan and ethnicity awareness policy and procedure that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a comprehensive guide that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The policy includes references to other Maori providers available and interpreter services.  D20.1i The service has established a link with iwi through a Maori Elder/Kaumatua who provides advice and training for all staff and provides advocacy for Maori residents.   Cultural awareness training was provided August 2013 (28 attended). The Maori health plan identifies the importance of whānau. Currently there are no Maori residents. Interviews with six HCAs confirmed knowledge of a Maori Health plan and could describe cultural awareness and sensitivity when delivering care to Maori residents. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Park Lane has policies and procedures to guide staff practice.  Individual culture, values and beliefs information is gathered on admission with resident/family involvement and is integrated into residents' care plans and activity plans. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services, spiritual visitors and attending their own church and other community groups as desired.  Care plans including cultural and spiritual beliefs are reviewed six monthly involving the resident/family and multidisciplinary team members to assess if the resident spiritual, cultural, values and beliefs are being met.  Interviews with eight residents (four rest home and four hospital) and seven relatives (four hospital and three rest home) confirmed they are involved in the care planning process and review of their spiritual, cultural, values and beliefs. D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Spirit and  D4.1c Care plans reviewed included the resident’s spiritual, cultural, values and beliefs social and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Code of Conduct and residents rights and responsibilities are included in the Employee Pack. Job descriptions include responsibility of the position. Signed copies of all employment documents sighted in staff files reviewed. There are policies in place to guide staff practice. Advised that management provide guidelines and mentoring for specific situations. There is a bi-monthly staff meeting and enrolled Nurse (EN) and Registered Nurse (RN) performance improvement meetings that includes any discussions on professional boundaries and concerns. Enrolled nurses work under the supervisor of RN’s. The Clinical Nurse Manager, Quality Assurance Manager, three RN’s and six health care assistants (HCA’s) interviewed are able to describe professional boundaries.  D16.5e: Health care assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with six HCAs could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Park Lane has a implemented a quality and risk management system at the facility supported by a number of meetings including (but not limited to); management meetings (weekly), health and safety, infection control, EN & RN performance improvement meetings, staff meetings, Approval group (restraint), food services, residents meetings. The service has implemented Healthcare Compliance policies and procedures. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Staff are aware of any policy/procedure review and sign to confirm they acknowledge and understand the document.  There is a comprehensive orientation programme in place and regular monitoring of employee progress and performance occurs. At an organisational level, there is a Facility Manager (owner/operator), Clinical Nurse Manager, Quality Assurance Manager and Education Co-ordinator to maintain 'best practice' guidelines/procedures. An extensive annual education programme includes internal and external education sessions and core competency assessments. HCAs have completed a national qualification through ACE (aged care education), Career Force or, are currently enrolled with Career Force to complete the national qualification in the support of the older person. Park Lane is proactive around following through and identifying quality improvements from internal audits, incidents/accidents, surveys and complaints. “Mini” in-services are held in conjunction with meetings that are refreshers/updates resulting from audits outcomes, concerns or staff request.  aA2.2 Services are provided at Park Lane that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring. D1.3 all approved service standards are adhered to. D17.7c There are implemented competencies for health care assistants, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The management promote an ”open door” policy. There is a residents meeting held regularly with opportunity for feedback on the services. The RN’s conduct resident rounds daily allowing an opportunity for open discussion with the residents. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Information is provided in formats suitable for the consumer and their family.  There is evidence of open disclosure documented in the resident file in regards to health status, medications, care planning, incidents and accidents.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Seven relatives and eight residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss information and the admission agreement with management.  D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b Seven relatives stated that they are always informed when their family members health status changes. D11.3 The information pack is available in large print and advised that this can be read to residents |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Park Lane has policies in place for advanced care planning, informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written consent is obtained for any invasive procedures, attending student nurses and general consent such as obtaining and sharing of medical information, photograph and outings. Six HCAs interviewed are able to describe situations where verbal consent is obtained. Copies of the residents enduring power of attorney (where available) is held on the residents file. Where a resident has been deemed incompetent the EPOA is actively involved in the residents care.   Review of seven resident files, (four hospital and three rest home) all included appropriately signed resuscitation forms, general consent forms and evidence that advance directives are actively discussed with residents and family. Discussions with the clinical nurse manager and three registered nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.  D13.1 there were seven admission agreements sighted and seven had been signed on the day of admission D3.1.d Discussion with seven family identified that the service actively involves them in decisions that affect their relative’s lives.  There is an advanced directive form that is completed appropriately. Resuscitation orders are completed for residents who are competent to make the decision. Education on informed consent was conducted as part of code of resident rights in July 2013 with 29 attendees. The admission agreement records informed consent and this is signed by residents and/or family. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed. Interviews with the facility manager and clinical nurse manager, described how residents are informed about advocacy and support.  Interviews with eight residents (four rest home and four hospital) confirmed that they are aware of their right to access advocacy. D4.1d; discussion with seven family identified that the service provides opportunities for the family/EPOA to be involved in decisions  ARC D4.1e, the resident file includes information on residents family/whanau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a policy to maintain links with family and community and this is identified with the resident on initial assessment and development of the activity care plan. Residents are supported to attend community activities and functions as appropriate. The service maintains key linkages with other community organisations and encourages speakers and entertainers to visit the facility. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs.  D3.1h;: Discussion with seven relatives confirm that they are encouraged to be involved with the service and care D3.1.e discussion with staff and relatives state residents are supported and encouraged to remain involved in the community and external groups such as Cashmere club, concerts and café visits. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The facility manager/owner operator and clinical nurse manager are the privacy officers for the organisation. There is evidence of verbal and written concerns addressed following the complaints procedure. Where appropriate surveys or internal auditing is completed as part of the monitoring process.  D13.3h. a complaints procedure is provided to residents within the information pack at entry. The complaints register for 2013 ( four written and one verbal) were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution to the satisfaction of the complainant. Outcomes of concerns/complaints are discussed at the management and staff meetings. Discussion with eight residents (four rest home and four hospital) and seven relatives (four hospital, three rest home) confirmed they were provided with information on complaints and complaints forms and are comfortable approaching management with any concerns/complaints. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Park Lane is a modern spacious facility that extends over three levels. There are 45 studio apartments certified to provide rest home care if required. Currently there are no rest home residents in the studio apartments. The second level is a 42 bed care centre providing rest home and hospital level of care. On the day of audit there are 21 rest home residents and 20 hospital level of care residents. There are no residents at the facility under the medical component of the certificate.  The facility is co-owned by a husband and wife team (Directors) with considerable experience in ownership and management of care facilities. The owner/operators sit on a Board with three other Directors with experience in business management, accountancy and property development. There is a three year business plan in place which covers financial and business goals, staffing and education, SWOT analysis (strength, weakness, opportunities and threats) and further stages of development including thee construction of villas on the adjacent land. Stage one of studio apartments and the care centre has been completed. There is a certificate for public use in place which expires 1 March 2014. In addition to the business plan there are specific annual quality objectives which cover operational and risk management aspects of the business (sighted). The service has not been in operation long enough for an annual review however it is recommended the annual quality objectives be reviewed regularly.    The Park Lane owner/operators (non-clinical) are responsible for the operational and financial aspect of the business and have attended training/updates on quality systems, infection control, employment law and leadership training. Park Lane has employed two experienced registered nurses, one in the role of clinical nurse manager and the other in the role of the quality assurance manager. There are job descriptions for both positions that include responsibilities and accountabilities. The clinical nurse manager and quality assurance manager have attended education and training relevant to their role.   ARC,D17.3di (rest home), D17.4b (hospital) the clinical nurse manager has maintained at least eight hours annually (since January 2013) of professional development activities related to managing a hospital. Records of professional development sighted. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During the temporary absence of the owner/operators manger, Park Lane is managed by the clinical nurse manager. The RN quality assurance manager provides cover in the absence of the clinical nurse leader.  D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are organisational policies to guide the facility to implement the quality management programme including (but not limited to); quality assurance and risk management programme, risk management schedule, quality improvement committee responsibilities and internal audit schedule. There is evidence that the quality system has been implemented. Quality improvement suggestion forms are used by staff and quality improvements are discussed and recorded on meeting minutes. The clinical nurse manager is the restraint and infection control co-ordinator. The maintenance person is the health and safety representative and has completed Stage 1 of the Health and Safety course  Interviews with three HCAs and three registered nurses confirmed that quality data is discussed at the staff meetings, RN and EN meetings, health and safety/infection control/quality meetings and service meetings (meeting minutes reviewed). Meeting minutes are made available to staff. Quality, infection control and accident/incident data is attached to the meeting minutes. The quality and risk management programme is designed to monitor contractual and standards compliance.  Clinical guidelines are in place to assist care staff with such issues as incontinence, challenging behaviour, diabetes, falls prevention, incontinence, nutrition and hydration, skin care and wound management and pain management. Assessment tools completed linked with resident care plans and are reviewed six monthly. There is an annual staff training programme that is implemented and based around policies and procedures. Internal audits are completed for care plans compliance, service delivery compliance (cultural/spiritual, diversional therapy, restraint, nutrition), medications, hand washing, privacy, laundry and cleaning, catering and environmental.  Surveys completed are; resident satisfaction (July 2013), next of kin survey (September 2013), employee survey (October 2013), contractors survey (November 2013). A food service survey in March 2013 resulted in an evening meal review with resident participation. All results were collated and corrective action plans developed where required and communicated to staff at meetings.  D5.4 The service has the appropriate policies and procedures to support service delivery. The service's policies (healthcare compliance solutions Ltd.) are developed and reviewed by an aged care consultant. Staff are required to read and sign to acknowledge new policies, information and minutes.  D19.3:There is a Quality and Risk management programme in place that includes health and safety and hazard identification. There is a current hazard register. There are health and safety objectives within the annually quality objectives.  D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. A repeat falls analysis is completed as indicated. A post investigation form is completed for all falls. Prevention strategies and corrective actions is documented in the residents care plan.   There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff (civil defence training October 2013), monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency.  There is a risk management schedule that includes identified risk, controls, persons responsible and a review process. Organisational risks are categorised as environmental and equipment, resident safety, financial risk, confidentiality, staff, food services and legal liability. As the service has not been in operation for a full year there has not been a formal review, however there is evidence of monthly collation, analysis and monitoring of infection control, restraint use, accidents/incidents and audit outcomes. Staff interviewed (six HCAs and three RNs) state they are kept informed, receive information and discuss risk management and quality assurance at the staff meetings. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| As part of risk management and health and safety framework, there is an accident/incident policy which includes reference to open disclosure, level of seriousness (from one to five), and the responsibility for investigation and quality improvements. There is evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue injury), skin tears, medication and wandering from the facility. There was no monitoring in place for the one resident who wandered from the facility as documented in the long term care plan. When an incident occurs the healthcare assistant (or staff discovering the incident) completes the accident/incident form and the RN will undertake an initial assessment. The RN will notify family and GP as required. The incident/accident is documented in the progress notes. The clinical nurse manager collects incident reports daily, investigates and reviews, and implements corrective actions as required. Monthly data is taken to the monthly quality improvement meeting and relevant staff meeting. The six healthcare assistants and three registered nurses interviewed could describe the process for reporting of incidents and accidents and open disclosure.  D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action and investigation flow chart.  D19.3c  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Minutes of the quality meetings, RN and EN performance improvement and staff meetings reflect a discussion of results.  Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. However, there is an improvement required around notifying of a gastric outbreak. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Discussions with the service (infection control coordinator) confirmed there were four residents with gastric intestinal symptoms July 2013. The GP was notified and the outbreak contained effectively to four residents. No staff were affected. There is a detailed report completed. |
| **Finding:** |
| While the gastric outbreak was well contained and managed including input from the CDHB infection control nurse. Public Health were not notified of the gastric outbreak |
| **Corrective Action:** |
| Ensure the public health is notified of any outbreak as per policy |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Incident/accident monthly data viewed for the facility in October 2013 identified 18 falls, four skin tears and one resident wandering from facility. Nine accident/incident forms sampled all demonstrated clinical follow up by a registered nurse/clinical nurse manager and monitoring (such as neuro obs post head injury) having been undertaken when indicated. Nine of nine accidents/incidents sampled had the corrective action documented in a short term or long term care plan. |
| **Finding:** |
| There was one incident form completed for a resident that wandered from the facility. While the long term care plan identified monitoring requirements, there was no documented evidence of identified monitoring post incident for this resident. |
| **Corrective Action:** |
| Ensure post incident monitoring is implemented as documented in the care plan. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| All staff were newly employed prior to the opening of the facility in January 2013. Recruitment, selection and appointment of staff policy is in place. All seven staff files reviewed evidenced reference and police checks and signed job descriptions. All registered nurses and the enrolled nurse (who has completed transition) have current practicing certificates. Current practicing certificates for the pharmacist, podiatrist and general practitioners are available. There is a comprehensive orientation package that new staff complete over a four week period. Orientation includes health and safety policy, fire evacuation procedures, hazard identification, infection control policies, hand hygiene competency and manual handling competency. The quality assurance manager identifies a suitably skilled staff member to be the 'buddy'. Interview of six healthcare assistants confirmed there is an orientation process provided that included a period of being buddied. A written knowledge/ questionnaire is completed for infection control and hazard management to confirm the staff members understanding of company policy and procedure. Staff attend a paid session with the quality assurance manager to complete and evaluate the orientation process. Six of seven staff files contained a completed orientation. One staff member (recently employed) has required an extension of time to complete the orientation. Park Lane conduct appraisal at 11 weeks employment and annually thereafter. Six of seven staff files had 11 week appraisals completed. One staff member is scheduled to have an 11 week appraisal within the next four weeks.   The service has recently appointed an Educator (qualified DT) for five hours a week to coordinate the annual training programme and maintain education records. There is an assigned in-service training manual that includes education provided and staff attendance. All education is evaluated with feedback used to plan future training. Education for 2013 includes; Liverpool care pathway, infection control, continence management, chemical safety, abuse and neglect, wound care, code of rights, cultural safety, restraint, and civil defence. There is an additional RN/EN education planner that includes clinical conditions and procedures. External trainers are utilised for specialist topics. Topical “mini” in-services take place weekly following clinical staff meetings. It is recommended a record of attendance is maintained. RN’s will be undertaking InterRAI training 2014.  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint, safe manual handling, hand hygiene, syringe driver competency and wound care, palliative care, catheterisation.  Two HCAs on night shift checking controlled drugs have not undertaken a medication competency. |

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Registered nurses (RN) only administer medications in the hospital and rest home. All RN’s have a current medication competency and have attended medication education. There are two RN’s on all shifts to check and administer medications and controlled drugs with the exception of three nights a week. |
| **Finding:** |
| There are two HCAs on night shift checking controlled drugs that have not undertaken a medication competency. Since the draft report the provider has confirmed these two staff members have completed a competency. |
| **Corrective Action:** |
| Ensure HCA’s checking controlled drugs undertake a medication competency |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staffing rosters were sighted and there are adequate number of staff on duty to meet the resident’s needs on different shifts. There are two RN’s on duty the morning and afternoon shift. There are two RN’s on four nights a week and one on three nights a week. The clinical nurse manager works full time Monday to Friday and provides call 24/7. The quality assurance manager/RN provides on call as required. Staff turnover was moderate within the first three months of operation however staffing has now stabilised. There is a staff workload monitoring policy which takes the acuity of residents into consideration when determining staff numbers on duty. Eight residents interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and resident register. These are paper based files. Resident records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry, potential residents have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. D13.3 The admission agreements reviewed in seven resident files align with a) -k) of the ARC contract.  D14.1 exclusions from the service are included in the admission agreement. D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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

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

ARHSS D4.2

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

##### **Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)**

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures. The admission information, medical notes, allied health notes, progress notes, staff input, resident and family input form the basis of the long term care plan developed within three weeks of admission. The activities assessment is competed within two weeks of admission.  Medical assessments are completed within 48 hours of admission by the GP in all seven resident files sampled. The GP examines the resident at least three monthly and records the resident as stable to be seen again in three months. Earlier reviews are evident for residents requiring more frequent monitoring. Residents are able to retain their own GP's. The service has contracted the services of a local GP who visits twice per week and provides on call cover 24/7. A range of assessment tools completed on admission are evident in the seven resident files sampled.  There is a verbal handover between shifts and written handover sheet with resident significant events documented. Progress notes are written each shift and are maintained.  All seven files reviewed (four hospital, three rest home) identified integration of allied health professionals including GP medical notes, podiatry notes, letters and referrals to other allied health professionals and specialists.  D16.2, 3, 4: The seven resident files reviewed identified that in all files a nursing assessment was completed within 24 hours and the long term care plan was completed within three weeks. There is documented evidence in resident files sampled that the care plans are reviewed by a registered nurse. Resident files sampled evidenced written evaluations are completed six monthly. D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP records the resident as stable and to be seen three monthly. More frequent examination occurs when a resident health status changes.   Three rest home resident files are sampled.  Four hospital resident files sampled.  Tracer Methodology:  Rest home XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer-Hospital XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Informed consents for storage and collection of information, delivery of care, photograph for ID and display, transport and outings, family involvement in assessment, care plans and evaluation of care plans, resuscitation. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, and long term care plan within the required timeframes. All resident files sampled (three rest home and four hospital) evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives (three rest home, four hospital) and residents (four hospital, four rest home) advised on interview that assessments were completed in the privacy of their room. A range of assessment tools were completed in resident files on admission and reviewed at least six monthly including (but not limited to): dietary profile, continence, Braden pressure area risk assessment, Coombes falls risk assessment, mobility, pain and Robinson’s acuity assessment. Assessment tools completed were not consistently signed and dated by the registered nurse completing the assessments. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Clinical risk assessment tools were evidenced completed on admission. |
| **Finding:** |
| Assessment tools completed were not consistently signed and dated by the registered nurse completing the assessments. |
| **Corrective Action:** |
| Ensure completed assessments are signed and dated by a registered nurse. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial nursing assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse or clinical coordinator develops the long term care plan from information gathered over the first three weeks of admission.   The long term care plan includes safety/potential for injury/risk assessment, mobility, continence/elimination, activities of daily living, dietary needs, medication, sleep/comfort/sexuality and intimacy, pain management, communication/sensory, memory loss/confusion, behaviour management, respiratory function, spiritual/cultural/social, skin/wound care.   The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk assessment tools and reviews, medical documents , test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), incident/accident and infection events summary and correspondence.   D16.3k, Short term care plans are available for use to document any changes in health needs. Short term care plans were evidenced for urinary tract infections and wounds (link improvements 1.3.6.1).  Medical GP notes and allied health professional progress notes are evident in the seven residents integrated files sampled. Relatives (three rest home, four hospital) interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events and changes in health status. |

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents' care plans are completed by the registered nurses. Care delivery is recorded by health care assistants on each shift and follow up by registered nurses is documented for any changes in residents condition reported (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short term care plans (STCPs) are available for use to document any changes in health needs with interventions. Improvements are required around STCPs.   The six health care assistants interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence and wound care products were sighted stored in each wing.   D18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for 16 residents. Wounds include: three grade I pressure areas, seven skin tears, one surgical wound, two SCC, one chronic leg ulcer (resident admitted with this), one haematoma and one diabetic foot ulcer. There is an improvement required around documenting the type of wound being treated on the wound care management plans. All wound pressure areas have pressure relieving devices documented within their wound management plan, pressure relief monitoring charts/turning charts and have been referred to dieticians for nutritional assessments. An incident/ accident form was evidenced completed for a grade I pressure area. Two residents were admitted to the service with pressure areas. The resident’s file reviewed of a resident with a diabetic foot ulcer evidences referral to and input from CDHB Diabetic Foot Clinic Podiatrist. The registered nurses and clinical manager (CM) interviewed described the referral process and related form for referral to a wound specialist or continence nurse.   There is a Wound and Skin Care Treatment Register. There is an improvement required around this being updated as was not current on day one of audit. 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 has occurred. The facility has registered nurse cover 24/7 and has a comprehensive ‘in service’ education programme and toolbox talks on areas identified as special interest. The service can refer/contact the community physiotherapist as required. During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation. |

##### **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:** PA Low |
| **Evidence:** |
| Fourteen of sixteen wound management plans documented the type of wound being treated. There is a Wound and Skin Care Register in place. Short term care plans are available for use to document any changes in health needs with interventions. |
| **Finding:** |
| (i)Two of 16 wound management plans did not document the type of wound currently being treated. The Wound and Skin Care Register was not current- one resident with a diabetic foot ulcer was not included in the register and the register is not consistently updated when wounds are resolved. (ii) Interventions documented in STCPs were minimal e.g. administer antibiotics. (iii) STCPs were not consistently evaluated to evidence resolution or improvement/deterioration of condition. |
| **Corrective Action:** |
| (i)Ensure the type of wound being treated is documented on wound care management plans. Ensure the Wound and Skin Care Register is updated when wounds have healed and when new wounds are identified. (ii) Ensure STCPs are evaluated to monitor progress towards achieving desired goal. |
| **Timeframe (days):** 30 *(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:** |
| Comprehensive social history is complete on or soon after admission and information gathered is included in the care plan. Residents are quick to feedback likes and dislikes to the activity coordinator. Feedback is also received from the resident meeting and satisfaction surveys. The diversional therapy care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.  The Diversional Therapist works Monday –Friday 09.30-15.00hrs. Activities are provided seven days a week. The programme is planned monthly. The RNs inform the Diversional Therapist if there are any changes to a resident’s physical and cognitive wellbeing that may have an impact on their level of participation in the activity programme. Residents are encouraged to maintain links with community groups such as the RSA, primary schools, Cashmere Club and church groups. The service has a volunteer who assist with the activities programme. Visitors to the home include musical entertainers, pet therapy, hairdresser and manicurist. The facility has a hairdressing salon. The facility has a van for outings.   There are twice weekly outings shopping and library visits are enjoyed. There are suggestions of activities on the programme for morning, afternoon and evening times at the weekends which staff can use when the Diversional Therapist is not on duty. Residents interviewed described that the activities programme included; a daily exercise programme, quizzes, bowls, happy hour, dancing, themed days, entertainers, baking and bingo. They also reported that they get ‘out and about” and enjoy the weekly van rides.   The residents enjoyed getting “dressed up” and wearing hats along with the staff on “Cup” day and having a fish ‘n’ chip evening. 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:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The registered nurse or clinical coordinator completes a care plan evaluation form prior to six monthly care plan review.  D16.4a Six monthly evaluations of the long term care plan are conducted and involve the GP, clinical manager or RN, health care assistants, Diversional Therapist, resident/family/whanau input. The resident/family are notified of the review by letter and invited to attend. The long term care plan is amended with each review if there are changes. The family/whanau communication form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were evidenced in use. Short term care plans are available and utilised. However there is an improvement required around the evaluation of short term care plans as documented in 1.3.6.1. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Referral to other health and disability services is evident in sample group of resident files. One resident’s file reviewed with a wound evidenced referral and visits to CDHB Diabetic Foot Clinic. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; speech and language therapist, physiotherapist, Nurse Maude, podiatrist, General Practitioner and hospice. There is evidence of GP discussion with families regarding referrals for treatment and options of care.  D 20.1 discussions with three registered nurses and clinical manager identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietician and other allied health professionals. |

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

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

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

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

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

ARC D21 ARHSS D21

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Medication policies align with accepted guidelines. Medications are stored in locked trolleys in the treatment room in the Care Centre (hospital/rest home). Controlled drugs are stored in a locked cupboard in the locked treatment room in the Care Centre and two people (one being an RN), must sign controlled drugs out. There is a nurse’s station/treatment room on each of the three levels (two levels are serviced apartments) and each treatment room has a medication trolley and controlled medication safe. The Care Centre treatment room on level two is currently in use and controlled medications are only stored in this location. The service uses four weekly blister packed medications. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.  There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheet. The medication folders include a list of specimen signatures and competencies. Registered nurses and enrolled nurses administer medications. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulizers. Medication management training was held in May 2013. There is currently one rest home resident self-administering inhaler and sub lingual medications. A registered nurse assessment to self-administer inhalers and sublingual spray were evidenced completed in medication folder and signed by the GP and reviewed three monthly. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. D16.5.e.i.2; Twelve of fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Two medication chart reviewed were for recent admissions. Medication audits are completed six monthly. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a large workable kitchen in a service area on the ground floor. There is a walk-in pantry.  The menu has been designed and reviewed by a Registered Dietician. Food is transported in insulated food carriers to the kitchen on each floor. There is a dining room on each floor. Meals are served to residents from the Bain marries in the kitchen. There is a lift near the service area that is used to transport the food carriers to each floor and dishes back to the kitchen. The cook plates and serves all meals from the Bain Maries in the kitchenette area in the care centre. Food temperatures are recorded prior to serving each meal. There are two cooks. Both cooks had attained NZQA standard 167- Food safety certificates. The cook on duty works from 08.30-17.30hrs and prepares both the lunchtime and evening meals, morning and afternoon teas. There are two kitchen hands on duty each morning. One works 08.00-13.00hrs and the other 07.00-14.00hrs. There is a kitchen hand/assistant on duty each evening who works 16.00-20.00hrs. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, high protein, and vegetarian.  Residents are able to provide feedback to the service, verbally to the staff, at residents meetings and through the annual resident/relative survey. Kitchen staff have attended infection control education and chemical safety training. Daily temperature checks of chiller, freezers, Bain maries and dishwasher are maintained. Residents interviewed reported satisfaction with the food service. Resident’s stated that suggestions regarding improvements to the evening meals have been responded to and the evening meals are much improved. Health care assistants were observed assisting those residents who needed assistance with feeding. D19.2 staff have been trained in safe food handling. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Infectious waste is disposed of appropriately. There are puncture proof containers for the disposal of sharps. Policies and procedures for the use and storage of chemicals are in place in line with legislation. Ecolab have installed automatic chemical dispensers for cleaning, laundry and kitchen. Safety Data sheets available and accessible for cleaning staff and are located in the locked chemical/cleaning cupboard and laundry. A chemical spills kit is available and there is an emergency flip chart detailing instructions in the case of chemical spills. Protective clothing is available including: face shields, aprons, and gloves. Sluice rooms have key pad locks. Staff interviewed were knowledgeable in the management of infectious waste, chemical safety and emergency procedures. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has been purpose built and is divided into three levels. Level one (ground level) and level three 45 studio/serviced apartments. There is also a large lounge/dining area for service apartment residents. Level two is the care centre (rest home/hospital all swing beds) and contains 42 resident rooms.  There are handrails in ensuites and hallways on each floor. All rooms and communal areas allow for safe use of mobility equipment. There are two lifts between the floors that are large enough for mobility equipment and an escort. The building displays a current CPU which was issued 15-2-13. The physical environment with the wide corridors and spacious rooms allow easy access and movement between communal areas and bedrooms. There is a maintenance plan in place for 2013. Hot water temperatures are monitored and recorded monthly and were evidenced to be within the accepted limits for residential aged care. Clinical equipment is calibrated, checked annually and tagged. Daily maintenance requests are addressed. A maintenance person is employed to provide scheduled and reactive maintenance with use of sub-contractors for specialised work e.g. plumber or electrician.  There is adequate storage areas for hoists, wheelchairs and other equipment. Three RNs and six health care assistants interviewed confirmed there are adequate resources to safely deliver care including hoists, shower chairs and trolley, pressure reliving mattresses and cushions, slippery sams, lifting belts and walking frames. External areas are attractively landscaped, well maintained and walk ways are safe. There is a large courtyard garden with outdoor seating. Umbrellas provide shade in the summer.  D15.3d The lounge areas are designed so that space and seating arrangements provide for individual and group activities.  D15.2e: There are quiet seating areas that provide privacy when required. There is a “meeting” room on the ground floor which can be used by residents and families should they require privacy. |

##### **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:** |
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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.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have en-suites and there are adequate number of toilets which are easily accessible from communal areas. Fixtures, fittings and floor and wall surfaces in bathrooms and toilets are made of accepted materials for this environment. Hot water temperature monitoring is completed monthly. A review of temperature monitoring records evidenced the water temperatures to be within 42-45oC. |

##### **Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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

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

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

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

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

##### **Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a large lounge dining area on the third floor (serviced apartments) and a lounge plus a computer room/ library.  On the second floor (Care Centre) there is a large lounge/separate dining area and quiet lounge. On the ground floor (serviced apartments) there is a separate dining room and large lounge. There is also a “meeting room” which is a lounge that residents care use for privacy. There is a hairdressing/beauty salon. |

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.6: There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service and how the service will manage in a worst case scenario pandemic event. Interviews with the caregiver and three registered nurses confirm staff are aware of emergency and security procedures. Fire training and security situations are part of orientation of new staff and emergency/fire drills have been conducted monthly as per records sighted. Last fire drill occurred 08-Nov-13. A fire services company conducts monthly checks. (Records sighted). All registered nurses have a current first aid certificates as sighted employee files and training/education records reviewed. An approved evacuation scheme was signed off by the New Zealand Fire Service on 19-Feb-13. Extra blankets are available. There is emergency lighting at the facility and torches and batteries are stored (sighted). There is a gas BBQ and adequate stored water. There is at least three days’ supply of food.  Residents' rooms, communal bathrooms and living areas all have call bells. All staff are aware of the emergency process. This was confirmed at interviews with the registered nurses and health care assistants. Residents are orientated to the call bell system on admission to the facility. Security policies and procedures are documented and implemented by staff. There is security lighting for after dark. The main doors are locked in the evenings. Anyone requiring entry after this time must use the call system and staff answer the door. All staff interviewed are familiar with security procedures. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has two residents who have been assessed as requiring the use of a restraint. A monthly restraint and enabler register is maintained.  The long term care plan includes the use of restraint, any risks known, cares to be delivered during restraint periods, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Restraint minimisation is discussed at the staff, quality and management meetings. The GP is involved in the restraint approval and review process. The Restraint Coordinator (registered nurse) has a signed job description that clearly defines the responsibilities of the role. There is an Approval group who meet three monthly with the Restraint coordinator to review restraint use, monitoring and evaluate restraint processes. Types of restraint have been approved for use by the approval group. The approval group meeting is open to RN’s and also includes the diversional therapist, HCA’s and the GP. All staff complete a restraint competency assessment annually. Restraint use is included in the orientation for clinical staff. Restraint education was provided in September 2013. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **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:** FA |
| **Evidence:**  The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation and consent is in consultation/partnership with the resident (as appropriate) or whanau, the facility restraint coordinator and GP. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies is documented on the behaviour chart of a resident with challenging behaviour. Restraint use is reviewed at least three monthly and also as part of monthly restraint register reviews and monthly RN/EN performance improvement meetings. Staff complete incident forms and report any accidents/incidents to the RN/Restraint coordinator in regards to restraint use and these are discussed at the RN and quality meeting and corrective actions initiated. Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least three monthly. There are restraint monitoring guidelines that include comfort, dignity and respect, communication and support, nutrition and hydration, toileting and personal hygiene, exercise, medication and equipment. Cares and interventions throughout the restraint episode is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of two hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment |

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

#### Standard 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:** FA |
| **Evidence:** |
| Restraint assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, staff observations, accident or incidents, review of clinical risk assessment tools, behaviour assessments. There is a restraint assessment authorisation and consent form and this completed in consultation and discussion with the resident/family/whanau. Care plans (t) reviewed of residents with restraint are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly by the Restraint coordinator and approval group. |

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

#### Standard 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:** FA |
| **Evidence:** |
| The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is a registered nurse and is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation and consent is in consultation/partnership with the resident (as appropriate) or whanau and the facility restraint coordinator. The RN may apply restraint in the case of emergencies however this is to be verified with the GP and an evaluation completed 24 hours after the episode  Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies is documented on the behaviour chart of a resident with challenging behaviour. Restraint use is reviewed at least three monthly and also as part of monthly restraint register reviews and monthly RN/EN performance improvement meetings. Staff complete incident forms and report any accidents/incidents to the RN/restraint coordinator in regards to restraint use and these are discussed at the RN and quality meeting and corrective actions initiated. Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least three monthly. There are restraint monitoring guidelines that include comfort, dignity and respect, communication and support, nutrition and hydration, toileting and personal hygiene, exercise, medication and equipment. Cares and interventions throughout the restraint episode is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of two hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **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:** FA |
| **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:** FA |
| **Evidence:** |
| The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). All first episodes of restraint are evaluated after 24 hours. Emergency use of restraint is to be evaluated 24 hours after the episode. Written evaluations are completed by the approval group at least three monthly as part of the medical review and six monthly as part of the long term care plan review. Families are included as part of this review. Effective de-escalation strategies are reviewed by the Approval group. Evaluation timeframes are determined by risk levels. The approval group review all restraint and enabler processes at least two yearly or earlier if required. |

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

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

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

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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 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:** FA |
| **Evidence:** |
| Individual approved restraint is reviewed at least three monthly as part of the medical review and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint coordinator and approval group. Incident/accidents are reviewed by the restraint coordinator. Corrective actions are monitored.  The restraint standards are being implemented and implementation is reviewed through internal audits (last in October 2013) and staff, approval group and management meetings. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The scope of the infection prevention and control programme policy are available. The clinical nurse manager is the infection control co-ordinator. There is a job description (signed) for the infection control coordinator with clearly defined guidelines, accountabilities and reporting structure. The infection control (IC) committee includes a cross section of staff from all areas of the service; IC co-ordinator, facility manager, quality assurance manager, food services, household, maintenance and laundry persons. Committee meeting minutes and reports are forwarded to the quality assurance/management meetings. The facility manager/owner operator reports any significant events as necessary to the Board of Directors.  There is an infection control programme contained within the IC policy and procedure manual that is appropriate for the size and complexity of the service. The service has not been in operation long enough for an annual review to have taken place. The programme includes activities such as hand hygiene, internal auditing, education and surveillance. Monthly monitoring occurs including surveillance, visual inspections of all areas and “shoulder tapping” with trends and actions reported back to staff in all areas. Infection control is a set agenda item at on all meeting agendas.  Visitors are encouraged to stay away if sick. Communal toilets/bathrooms have hand hygiene notices. There is a staff health policy in place to ensure staff do not spread infections. The facility has signage to use for outbreaks and displays this information as needed. There is an outbreak management “bin” readily accessible for staff to set up bedrooms and toilets for isolation. An outbreak register is maintained. There was an outbreak of gastro-intestinal symptoms (July 2013) which involved four residents and no staff. The outbreak was effectively contained. The GP and next of kin were notified. There was no notification to Public Health (see link 1.2.4.2). A detailed records of events and actions are documented. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection prevention and control committee is made up of a cross section of staff from all areas of the service. Meetings are held monthly (minutes sighted). The facility also has access to infection prevention and control nurses from the Canterbury DHB, IC consultant, Southern Community public health nurses, Bugs control membership, G.P's and Laboratory services. Internet access is available.  The infection control (IC) coordinator has access to on-going education as needed and feels well supported by the company. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D 19.2a: Park Lane IC policies and procedures are developed by an aged care consultant with input from an IC consultant. The policies and procedures meet current accepted good practice and relevant legislative requirements. The policies are amended as required to meet the type of service provided. The manual includes (but not limited to) policies on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment. There is also policy on waste disposal. Infection control procedures are included in the kitchen, laundry and the housekeeping manuals. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator is responsible for coordinating and providing education and training to staff. The IC coordinator and facility manager has attended education through the DHB study days, Bugs control and on-site in service provided by external trainers. The IC co-ordinator is enrolled to attend an infection control course at the Christchurch Polytechnic in 2014. Infection control education for IC committee members and all staff was provided in October 2013 by and IC consultant. The dietician provided education for food services staff on safe food handling September 2013. Written evaluations are received on all education provided. Records of staff attendance is maintained. All staff employed when the service opened in January 2013 completed a comprehensive orientation including specific training around hand washing and standard precautions. Residents and relatives are provided with education on influenza prior to flu vaccinations occurring. Infection control education occurs as appropriate with individual residents. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. An individual resident infection summary of infection control rates and types are held in the resident's file. All infections are entered onto a monthly data collection and analysis form. A monthly report is completed by the infection control co-ordinator, which is available in the nurse’s office. Data collection, trends and analysis are reported to the facility manager/owner operator, IC committee, monthly quality meetings and staff meetings. Standardised definitions of infections are in place and are appropriate to the complexity of service provided. Infection surveillance includes eye, skin, UTI, influenza, chest and other infections. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Remedies are developed when needed and CARS are put in place. Internal audits occur (last audit was completed in October 2013.). Six HCAs and three RN’s confirmed on interview they receive audit results, data collection of monthly infections. Infection control is discussed at staff meetings. There is close liaison with the GP's who advise and provide feedback to the service as evidenced in medical notes and outbreak management documentation.  The service has not been in operation for a full year and are in the process of evaluating outcomes of quality initiatives and data collection as part of continuous improvement and goal setting for the upcoming year. |

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

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

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

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