# Deakoda Holdings Limited

## Current Status: 7 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

Shalom Aged Care provides rest home level care for up to 30 residents. On the day of the audit there were 28 residents. The two owners are actively involved in the management of the facility. They provide on-going support to the manager who in turn is supported by two registered nurses and a team of support staff. The owners and staff are committed to providing the highest quality care and support to residents and their families. The focus is on providing a small family environment. There is a strategic and business plan in place and a range of policies and procedures to guide practice. The quality and risk management system is well embedded within the service. Staff are actively involved through discussions, meetings, and the reporting of any concerns, incidents or accidents. Staff turnover is low. Residents and relatives spoken to on the day of audit were very complimentary about the services they receive and have appreciated the investment that the owners have made to the facility.

Improvements are required around the signing of documentation by staff, medicines management, and the storage of chemicals in the laundry.

## Audit Summary as at 7 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 7 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 7 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 7 November 2013

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

### Safe and Appropriate Environment as at 7 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 7 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 7 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 7 November 2013

### Consumer Rights

Residents and their families are provided with information about the services offered, and their rights on entry to the facility. Residents meetings are held monthly and the health advocate attends these meetings. Staff respect residents’ privacy, values and beliefs. Individual choice is encouraged. All residents are able to retain their own general practitioner. Family/whanau visiting and links with the community are encouraged. Relatives are kept informed about resident’s care as appropriate.

### Organisational Management

The manager has been in the position for five years and is supported by two registered nurses. The manager meets weekly with the owners of the rest home. There is a quality assurance programme in place that is known to staff. The programme includes policies and procedures, internal audits, complaints management, infection prevention and control, and health and safety. Quality assurance and quality improvements are discussed at the regular management and staff meetings. Staff participate in on-going education. Caregivers have completed, or are enrolled in, the Aged Care Education (ACE) programme or an equivalent. Staffing levels are appropriate. The registered nurses are available to provide on call support at any time. Improvements are required around the signing of staff designations in clinical records.

### Continuum of Service Delivery

The service has policies and procedures in place covering the continuum of service delivery. A range of information is available to people prior to entry to the facility. There are formal systems in place when residents are admitted. Following admission a range of assessments are conducted and an initial plan of care is developed by a registered nurse and then implemented. Once the registered nurses and staff have completed the initial assessment process for a newly admitted resident, a long term care plan is developed to guide practice. This plan is agreed between the resident, their relatives (where appropriate), staff and the resident’s general practitioner (GP). Registered nurses are responsible for overseeing each stage of service provision. Service delivery plans demonstrate service integration. A varied individual and group activities programme is provided to suit the needs and interests of the residents. Group activities include external outings. Plans of care are evaluated on an on-going basis and formally reviewed every six months or when there are changes in a resident’s health status. Residents are referred to other health and disability providers when necessary. The service maintains links with primary care practices, a local pharmacy, a podiatrist, a physiotherapist and specialist staff from the Whangarei District Health Board. There is a medicine management system in place. All food is prepared in the kitchen. Residents and relatives spoken to on the day of audit are very satisfied with the standard of services provided including standard of the food service. Improvements are required to the medicines management system.

### Safe and Appropriate Environment

The building has a current warrant of fitness and approved fire systems are in place. The owners have successfully implemented a process of renovation and decoration to make the building highly age appropriate and to ensure it meets the needs of both residents and staff. The grounds are attractively landscaped and residents can relax outdoors weather permitting. Many of the bedrooms have external doors. The kitchen has been entirely modernised. There are waste management policies and procedures in place to guide staff. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. All electrical equipment is checked to ensure safety. Residents are able to bring their own possessions. Consideration is given to residents needs when purchasing new furniture/equipment. There is an improvement required to the storage of two large containers of chemicals in the laundry.

### Restraint Minimisation and Safe Practice

No residents were using enablers on the day of audit. On occasion enablers are used by residents to enhance their mobility or to promote their safety. There are policies in place to guide practice when these situations occur. Consent processes are observed and documented. Staff attend training on the use of enablers and restraint although restraint is not usually required for residents. If a resident required a restraint and was not able to agree to its use then it is likely that the resident would be reassessed with a view to transfer to a more appropriate aged care facility.

### Infection Prevention and Control

There are infection prevention and control policies and procedures in place. The infection prevention and control programme is managed by the registered nurses. The programme is appropriate for the size and complexity of the service. The surveillance programme is well documented and findings are relayed to staff and residents as appropriate. Staff receive on-going training in infection prevention and control. Residents and staff use hand gel to clean their hands and reduce the risk of infections. There have been no outbreaks of disease since the previous audit.

# HealthCERT Aged Residential Care Audit Report (version 3.9)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Deakoda Holdings Limited |
| **Certificate name:** | Shalom Aged Care |

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| **Designated Auditing Agency:** | Health & Disability Auditing New Zealand Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | Shalom Aged Care, 62-64 Mill Road, Kensington, Whangarei | | | |
| **Services audited:** | Rest home | | | |
| **Dates of audit:** | **Start date:** | 7 November 2013 | **End date:** | 7 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:** | 28 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 8 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 16 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | 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 Auditing Agency has finished editing the document. | Yes |

Dated Monday, 16 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Shalom Aged Care provides rest home level care for up to 30 residents. On the day of the audit there were 28 residents. The two owners are actively involved in the management of the facility. They provide on-going support to the manager who in turn is supported by two registered nurses and a team of support staff. The owners and staff are committed to providing the highest quality care and support to residents and their families. The focus is on providing a small family environment. There is a strategic and business plan in place and a range of policies and procedures to guide practice. The quality and risk management system is well embedded within the service. Staff are actively involved through discussions, meetings, and the reporting of any concerns, incidents or accidents. Staff turnover is low. Residents and relatives spoken to on the day of audit were very complimentary about the services they receive and have appreciated the investment that the owners have made to the facility.  Improvements are required around the signing of documentation by staff, medicines management, and the storage of chemicals in the laundry. |

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| **Outcome 1.1: Consumer Rights** |
| Residents and their families are provided with information about the services offered, and their rights on entry to the facility. Residents meetings are held monthly and the health advocate attends these meetings. Staff respect residents’ privacy, values and beliefs. Individual choice is encouraged. All residents are able to retain their own general practitioner. Family/whanau visiting and links with the community are encouraged. Relatives are kept informed about resident’s care as appropriate.  . |

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| **Outcome 1.2: Organisational Management** |
| The manager has been in the position for five years and is supported by two registered nurses. The manager meets weekly with the owners of the rest home. There is a quality assurance programme in place that is known to staff. The programme includes policies and procedures, internal audits, complaints management, infection prevention and control, and health and safety. Quality assurance and quality improvements are discussed at the regular management and staff meetings. Staff participate in on-going education. Caregivers have completed, or are enrolled in, the Aged Care Education (ACE) programme or an equivalent. Staffing levels are appropriate. The registered nurses are available to provide on call support at any time. Improvements are required around the signing of staff designations in clinical records. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has policies and procedures in place covering the continuum of service delivery. A range of information is available to people prior to entry to the facility. There are formal systems in place when residents are admitted. Following admission a range of assessments are conducted and an initial plan of care is developed by a registered nurse and then implemented. Once the registered nurses and staff have completed the initial assessment process for a newly admitted resident, a long term care plan is developed to guide practice. This plan is agreed between the resident, their relatives (where appropriate), staff and the resident’s general practitioner (GP). Registered nurses are responsible for overseeing each stage of service provision. Service delivery plans demonstrate service integration. A varied individual and group activities programme is provided to suit the needs and interests of the residents. Group activities include external outings. Plans of care are evaluated on an on-going basis and formally reviewed every six months or when there are changes in a resident’s health status. Residents are referred to other health and disability providers when necessary. The service maintains links with primary care practices, a local pharmacy, a podiatrist, a physiotherapist and specialist staff from the Whangarei District Health Board. There is a medicine management system in place. All food is prepared in the kitchen. Residents and relatives spoken to on the day of audit are very satisfied with the standard of services provided including standard of the food service. Improvements are required to the medicines management system. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current warrant of fitness and approved fire systems are in place. The owners have successfully implemented a process of renovation and decoration to make the building highly age appropriate and to ensure it meets the needs of both residents and staff. The grounds are attractively landscaped and residents can relax outdoors weather permitting. Many of the bedrooms have external doors. The kitchen has been entirely modernised. There are waste management policies and procedures in place to guide staff. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. All electrical equipment is checked to ensure safety. Residents are able to bring their own possessions. Consideration is given to residents needs when purchasing new furniture/equipment. There is an improvement required to the storage of two large containers of chemicals in the laundry. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| No residents were using enablers on the day of audit. On occasion enablers are used by residents to enhance their mobility or to promote their safety. There are policies in place to guide practice when these situations occur. Consent processes are observed and documented. Staff attend training on the use of enablers and restraint although restraint is not usually required for residents. If a resident required a restraint and was not able to agree to its use then it is likely that the resident would be reassessed with a view to transfer to a more appropriate aged care facility. |

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| **Outcome 3: Infection Prevention and Control** |
| There are infection prevention and control policies and procedures in place. The infection prevention and control programme is managed by the registered nurses. The programme is appropriate for the size and complexity of the service. The surveillance programme is well documented and findings are relayed to staff and residents as appropriate. Staff receive on-going training in infection prevention and control. Residents and staff use hand gel to clean their hands and reduce the risk of infections. There have been no outbreaks of disease since the previous audit. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 3 | 1 | 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 | 5 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 8 | 0 | 0 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Low | Registered nurses are not consistently recording their designation. | Ensure that the designation is entered for all resident records. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Staff have not correctly reconciled medicines received from the pharmacy against the medicine orders and have administered medicines without checking the medicine order to determine if the order is legible and signed. Staff have not rechecked the medicine order prior to administration of the medicine. The RNs were advised of all medicine ordering errors noted during the audit. Prescribed orders for PRN medicine orders are not always charted correctly (i.e., they do not specify the specific target symptoms, instructions for the PRN medicine use and the rationale for using the PRN medicine). There is no recorded evidence in the controlled drug register of six monthly stocktakes and reconciliations. | Ensure medicine orders are dated and signed by the prescriber and that PRN medicines orders specify the specific target symptoms, the instructions for the PRN medicine use and the rationale for using the PRN medicine. Ensure a six-monthly stocktake and reconciliation of controlled drugs occurs and a record of this procedure is recorded in the controlled drug register. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | One resident who is self-administering a medicine has not been formally reviewed every three months. | Ensure residents who self-administer medicines are formally reviewed three monthly. | 90 |
| HDS(C)S.2008 | Standard 1.4.6: Cleaning And Laundry Services | Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.6.3 | Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Low | All chemicals in the laundry were not able to be stored securely as the containers that they are stored in are too large to be stored in the secure storage cupboard. | Ensure all chemicals are stored securely in the laundry | 30 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy on resident rights. The code of rights posters are displayed in the facility. Staff competencies are completed as part of the internal audit process and include the code of rights (completed 3 October 2013). In-service was also provided on 26 March 2013. Caregivers are familiar with the code of rights (confirmed during interview with two of two caregivers).  D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. There is entry information and welcome package provided to residents/family at entry to the service. Interviews with six of six residents describe the information provided. This includes advice about key areas such as rights, advocacy, complaints, services and fees. Large posters of the code of rights are displayed in English and Maori. |

##### **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:** |
| A copy of the code of rights pamphlet is given to residents as part of the information pack given on entry. Audiotapes are available if required. The manager ensures that people have the opportunity to ask questions and to seek clarification on any of the information provided on or before entry. The health and disability advocate attends the monthly residents’ meetings. Contact information for the health advocate and her photograph are displayed in the lounge. Residents and family members are familiar with the code of rights (confirmed during interview with six of six residents and six of six family members).  D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, a copy of the COR pamphlet, and information on the nationwide health and disability advocacy service. |

##### **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:** |
| Policies on privacy, sexuality and intimacy and the recognition of individual values and beliefs address how Shalom respects and delivers services in a manner that has regard for the resident’s dignity, privacy, and independence. Staff sign confidentiality agreements (sighted in eight of eight personnel files). There are single rooms for privacy and the two shared rooms (one double room is shared by a couple). Curtains are in place to maintain privacy. One resident who shares a room states that she is happy to do so and confirms that her privacy is respected (confirmed during interview with this resident). Residents are addressed by their preferred name and this is documented on the file. Spiritual needs are met and supported by the service. Residents and family members are positive about the care and praised staff for the individual support given. Residents state that they can go on outings at any time (confirmed during interview with six of six residents and six of six family members). Cultural, social, spiritual and emotional needs are identified in residents' care plans (sighted in six of six resident files). Satisfaction with the care, privacy and respect shown to residents is confirmed in the family and resident satisfaction surveys completed in August 2013.  Monthly church services are held at Shalom and Catholic communion occurs weekly. Some residents attend their own church services in the community.   A policy on the detection and removal - abuse and neglect defines abuse and neglect and describes reporting processes. In-service training on abuse and neglect occurred in April and August 2012 and September 2013. Staff describe procedures for maintaining confidentiality, respect for privacy and how resident’s needs are met (confirmed during interview with two of two caregivers).  D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. This is described in the business plan and information given to new residents and staff. 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. D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A Maori Health Plan and cultural safety policies are in place to support Maori residents and whanau. The importance of whanau is identified in the policy. The service is able to access and consult local advice should they provide services to a Maori resident through Ngati Hine Health Trust, Kia Ora Ngati Wai or a kaumatua from the Anglican or Catholic churches. Family members are encouraged to visit (confirmed during interview with six of six residents and six of six family members and observed during the audit). Maori health is addressed in information given to new employees. There are no Maori residents. One staff member is Maori.  Resident and family satisfaction surveys (completed in August 2013) confirm that visitors are welcome.  A3.2 There is a Maori health plan that includes a description of how Shalom will achieve the requirements set out in A3.1 (a) to (e) D20.1i The service has developed links with Ngati Hine Health Trust, Kia Ora Ngati Wai and kaumatua from the Anglican and Catholic churches. |

##### **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:** |
| Caregivers describe the importance of individual values and beliefs. As the facility is small they get to know residents well (confirmed during interview with two caregivers). Residents and family confirm that the resident’s values and beliefs are observed and that they are consulted about their values and beliefs (confirmed during interview with six of six residents and six of six family members). Resident and family satisfaction surveys (completed in August 2013) confirm that residents can continue their cultural and religious practices and have input into the care of the resident.  D3.1g The service provides a culturally appropriate service by. Through the acknowledgement of, and respect for, each resident’s values and beliefs. D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies on sexuality and intimacy and the detection and removal - abuse and neglect, employment guidelines and house rules describe professional boundaries and the implementation of an environment free from discrimination and exploitation. Each role has a position description that describes the fnctional relationships and responsibilities of the position. Staff attended an in-service that included Shalom’s philosophy on 3 October 2013.  Residents and relatives express their appreciation of the caring nature of staff and their professionalism. They also state that the two owners are very approachable (confirmed during interview with six of six residents and six of six family members). Caregivers are familiar with the expectations of their role (confirmed during interview with two of two caregivers). |

##### **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:** |
| Services are provided at Shalom Rest Home that adhere to the health & disability services standards. The owners meet weekly with the manager. There is an implemented quality improvement programme that includes performance monitoring. There are a number of implemented competencies completed by staff and clear ethical and professional standards and boundaries within position descriptions. Appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. Staff participate in ongoing professional development, for example the two registered nurses attended a course on medicines and the older person in May 2013 and an update on cardiovascular care and medicine management in June 1 2013.   Residents and family members state that the rest home is 'home-like' and the care provided by staff is excellent (confirmed during interview with six of six residents and six of six family members. |

##### **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 service has a policy on consultation of the resident and a policy on open disclosure. Residents/visitors and family were observed having private conversations during the audit. Staff are easily identifiable and wear uniforms and name badges. Interpreter services can be accessed through the Citizens Advice Bureau and the public library holds a list of interpreters. The accident/incident form includes a section on whether the family has been informed of the event (confirmed sign off sighted on 10 of 10 incident forms)   Relatives are sent a letter informing them that 'Shalom provides a yearly family meeting to give the family an opportunity to discuss any concerns they may have'. Letters were sighted in resident files. Monthly resident meetings ensure that residents are informed about facility activity.  Family members state that they are informed about changes in the resident and/or any incidents or accidents involving the resident (confirmed during interview with six of six family members). Family members who responded to the family satisfaction survey, held in August 2013, confirm that they are notified about concerns. A letter was sent to one family member in response to suggestions made in the family satisfaction survey held in August 2013. |

##### **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:** |
| There are established informed consent policies and procedures, a resuscitation policy and an advanced directives form. Information on informed consent is discussed with residents and families at admission. There is a Resident Admission Agreement. Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights are in place. The service provides residents and families with information on entry to the service and thereafter when decisions or information is needed (confirmed in discussions with six of six residents and six of six relatives). Staff discussions showed an understanding of the key principles for the Code of Consumer Rights and informed consent (confirmed in discussions with the manager, two of two registered nurses, and two of two caregivers). The service is able to demonstrate that written consent is obtained where required. Advance directives that are made available to service providers are acted on where valid.  D13.1 There were six admission agreements sighted and of these six, four agreements had been signed on the day of admission and the other two had been signed within days of admission as they had been admitted directly from the DHB.  D3.1.d Discussion with six of six family identified that the service actively involves them in decisions that affect their relatives lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and families are informed of their right to access advocacy services on admission. The health advocate attends the monthly residents’ meetings. Contact information for the health advocate, including her photograph, are displayed in the lounge. Advocacy training is included in the code of right training that was most recently last completed June 2011. Advocacy is included in the code of right training and last completed on 3 October 2013. Caregivers are able to describe the principles of advocacy (confirmed during interview with two of two caregivers).  D4.1d; Interviews with six of six residents and six of six family identifies that the service provides opportunities for the resident and family (where appropriate) to be involved in decisions. Residents and families are informed of their right to access advocacy services on admission and staff are able to describe the principles of advocacy  ARC D4.1e: The resident file includes information on resident’s 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:** |
| Visitors were observed with residents during the audit. Residents and family members state that family are made welcome and are able to visit at any time. Residents also state that they can go on outings at any time and can participate in community groups, for example card clubs, church services and the Parkinson’s group (confirmed during interview with six of six residents and six of six family members). The activities’ programme includes visits by community groups and regular outings into the community, for example entertainers and the mobile library visit the facility, there is monthly church service and outings include visits to a local day care centre and participation in ASB community fundraising through a cake stall and sausage sizzle.  D3.1h Discussion with six of six family members confirms that they are encouraged to be involved with the service and the resident’s care including being involved in the care planning process. The service has visiting arrangements that are suitable to residents and family/whānau. Families interviewed stated that they are able to visit at times that meet their needs and examples were provided in interview. Families were seen to visit and all are welcomed, provided with information on their family member and offered a cup of tea. Residents are supported to access the community. This includes church services, community activities and family outings. D3.1.e Discussion with owners, the manager, two caregivers and six residents confirms that residents are supported and encouraged to remain involved in the community. |

##### **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:** |
| There are complaint management policies and procedures aligned with the code of rights. The complaints procedure is provided to residents at entry as part of the information pack. Complaints forms are available in the reception area. The manager maintains a complaints' register that includes all documentation related to a complaint. The most recent complaint was received on 29 September 2012. The register records the date received, the name of the complainant and the resident, names of any staff members involved, the reason for the complaint and actions taken including discussions with the complainant. Residents and relatives are familiar with the complaints process (confirmed in discussions with six of six residents and six of six relatives).  D13.3h. The complaints procedure is provided to residents within the information pack at entry. |

##### **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:** |
| Shalom Aged Care is situated in Whangarei providing care for 28 of 30 residents. The current owners have owned the business for three years, visit weekly and provide support to the management team. There is a strategic plan, a business plan and a Maori Health plan. Plans are reviewed annually by the owners/management team. The business plan includes the philosophy of the business, strategic goals and quality assurance and monitoring processes.   The manager provides operational management for the service. She has been in the position for five years and has 17 years aged residential care experience, including activities coordination. A position description is in place. She has completed eight hours of management related education in the past year including attendance at the New Zealand Aged Care Association (NZACA) training day held in May 2013. She plans to attend an Age Concern course on the enduring power of attorney (EPOA) in November 2013.   ARC,D17.3di (rest home) The manager has maintained at least eight hours annually of professional development activities related to managing a facility. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The quality and risk management system is described in the business plan and includes a set of goals for 2011 to 2013 and related monitoring processes. The manager meets weekly with one of the owners. There is a management meeting between the manager and a registered nurse where issues including resident issues, resources, training, health and safety, occupancy and infection control are discussed. The quality and risk management programme is documented and reviewed at the combined six weekly staff meetings. These are held regularly. A new agenda format has been introduced. Quality data and themes are discussed on a regular basis with staff. Data on accidents and incidents by type, infections and complaints and compliments are discussed at staff meetings. Restraint is not discussed unless enablers or restraint are in use. At the time of the audit no residents were using enablers or restraint. Accident/incident and infection data is provided in graphic format. Residents attend monthly meetings and annual satisfaction surveys are completed. There is an implemented health and safety programme and a health and safety representative.  Staff are kept informed about quality information at their regular meetings and through information posted in the nurses’ station (confirmed during interview with two of two caregivers).  A document control policy is in place. A document control system is implemented that includes the name of the policy and the manual and the version number. There is a master list of policies that have been reviewed with dates of review documented. Policies and procedures are reviewed and updated every two years or at times of significant change. Policies are available to staff in the nurses’ station. Obsolete policies are archived. The manager and the registered nurses ensure that they are kept up to date with current practice through on going professional development and information received from professional bodies in the aged care sector.   An annual internal audit programme is implemented. Each audit is recorded on an audit sheet that has a space for the documentation of any corrective actions. Completed corrective actions are signed off by the manager. The follow-up for completion of corrective actions is fully monitored and documented with evidence of resolution of issues. Copies of the results of each audit are posted in the staff room. Internal audits completed in 2013 include resident admission, waste management, cleaning, food handling, laundry, kitchen safety, pest control, continence and the code of rights. A safety audit is completed three monthly by the health and safety representative and building inspections are completed monthly.  There is a risk management plan documented in the business plan that identifies key risks by category, subsets and examples. Controls are listed as part of their analysis. Risks are monitored through the quality management system and reviewed annually at the time of the review of the business plan.   D5.4 The service has the following policies/ procedures to support service delivery. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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:** FA |
| **Evidence:** |
| The service has a health and safety policy that describes employer and employee responsibilities and an incident/accident reporting policy. Individual incidents are reviewed by relevant staff and management. Incidents are documented, investigated and analysed by the manager. Incidents are discussed at the six weekly staff meeting and monthly management meetings with information used to improve the service. The accident/incident form includes a section on whether the family has been informed of the event (confirmed sign off sighted on 10 of 10 incident forms). The form used for reporting incidents records the nature of the event, date, those involved, those notified, contributing factors and completed follow up action. Completed follow up action and the date was sighted on 10 of 10 incident forms. There is a hazard identification process and a current hazard register. Reported hazards are monitored during the three monthly safety audits. Shalom Aged Care is aware of notification responsibilities. An outbreak of norovirus was reported to the DHB on 19 September 2012 (norovirus outbreak report form sighted). Outbreak meetings were held in the facility during the outbreak (minutes sighted).  Staff describe the incident reporting process and their role (confirmed during interview with two of two caregivers). D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents. |

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

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

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

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

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

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| **Attainment and Risk:** 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 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies are implemented for recruitment, selection and appointment of staff. Application forms are placed in personnel files (sighted in eight of eight files – two registered nurses, one activities officer, one cook and four caregivers). Police and referee checks are completed when potential employees are not known to management. There is a policy on staff orientation/training. New employees complete a comprehensive orientation programme that includes a buddy system. They are given a package of information that addresses key issues and policies related to the facility and resident care. An orientation checklist is completed (sighted in eight of eight personnel files). Position descriptions that describe functional relationships, responsibilities and expected outcomes are in place for all roles. There is an annual training plan and a record is kept of training completed by each employee. Copies of certificates are filed in personnel files. A regular in-service training programme is in place and in the past two years has included restraint, elder abuse, falls prevention, infection control, cultural safety, pain management/palliative care and continence management. A number of staff have attended training at Age Concern. Shalom Aged Care employs 14 caregivers. Four of 14 are casual staff. 13 of 14 caregivers have completed the Aged Care Education (ACE) programme or an equivalent. One is currently enrolled in the ACE programme. One caregiver is a workplace assessor. Caregivers complete competencies in medicine administration and all staff complete competencies in emergency management, infection control and the Code of Rights. Performance appraisals are completed annually. Staff state that their orientation is comprehensive, that they have an annual performance appraisal, there is regular in-service education and they are encouraged to participate in ongoing education (confirmed during interview with two of two caregivers).  Copies of current practising certificates for the two registered nurses, the diettian, the podiatrist, the physiotherapist and 15 general practitioners who visit the facility is kept by Shalom Aged Care. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The staff/skills mix policy provides the documented rationale for staffing. Rosters are in place for allocation of staffing levels across shifts. Staffing is as follows. The two registered nurses share cover for each day of the week and take turns to be on call 24/7. On call contact information is written at the top of each roster. A copy is kept in the nurses’ station. The manager works 32 hours over four days of the week. Weekdays 1 caregiver 0645- 1530 1 caregiver 0645 - 1500 1 caregiver 0645 - 0930  2 caregivers 1515- 2100 1 senior caregiver 2045- 0700 Weekends 2 caregivers 0645- 1530 2 caregivers 1515- 2100 1 senior caregiver 2045- 0700  Staff and residents/family state that there are sufficient staff on duty (confirmed during interview with two of two caregivers, six of six residents and six of six family members). |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service retains relevant and appropriate information to identify residents and track records. There are resident files in use appropriate to the service. Files are hard copy and are securely stored in the nurse's room. A database maintains a record of all past and present residents. Records are archived in line with the clinical records policy for past residents. Entries are legible, dated and signed by the relevant caregiver or registered nurse. The registered nurses’ designation is inconsistently recorded in resident’s notes. Documentation is current and accurate and includes the resident’s unique identifier. Resident files include integrated care planning information (sighted in six of six resident files). Medication administration is kept in a separate folder. A communication book is also used.  D7.1 Entries are legible, dates and signed by the relevant caregiver or registered nurse. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A review of six of six clinical records showed that the registered nurses were signing entries but not always including their designation. |
| **Finding:** |
| Registered nurses are not consistently recording their designation. |
| **Corrective Action:** |
| Ensure that the designation is entered for all resident records. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The admission policy and resident information handbook outline access, assessment and entry screening processes. The local community and NASC service are familiar with entry criteria and how to access the service. The service operates 24 hours a day, 7 days a week. Comprehensive information about the service is made available to referrers, potential residents and new residents and their families. Resident agreements are based on the Aged Care Association template document and contain all of the details required under the ARC contract. Residents and relatives are provided with information about entry processes and how to access the service including the requirement for a needs assessment at the point of their first enquiry to the service (confirmed in dicussions with six of six residents and six of six relatives).  D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract (the format follows the NZ Aged Care Association Template) 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:** |
| There is an acceptance and declining entry to service policy. Consumers are advised of decline of entry when there are no beds available or, if the resident needs level are not at a level provided by the service. The service has not declined entry to a prospective rest home resident for several years (confirmed in discussion with the manager). |

##### **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:** |
| Assessment, planning, evaluation, review and exit are undertaken by a registered nurse with input from the resident, their family, other health professionals and caregivers. Service delivery is primarily undertaken by caregiving staff under the guidance of the two registered nurses. Residents and relatives interviewed confirm they are involved in the assessment and planning process (confirmed in discussions with six of six residents and six of six relatives). Residents are encouraged to be as independent as possible. Assessment, care planning and evaluation are occurring within contracted time frames to safely meet the needs of the resident. GP's are assessing residents within two working days of entry to the facility and three monthly thereafter once they consider the resident to be medically stable (confirmed in review of six of six clinical records). The service has a variety of processes in place to ensure a co-ordinated service. The open disclosure policy describes the ways in which staff ensure residents and their families are kept informed of residents' health status and wellbeing, including changes. Admission and assessment policies clearly identify appropriate timeframes ensuring the resident receives timely assessment, following best practise and legislative guidelines. Residents’ assessments include but are not limited to an assessment of skin integrity, mobility, falls risk, pain assessment if appropriate, continence, nutritional profile, behavioural assessment if appropriate. An initial care plan is developed on the day of admission and a long term care plan is developed within three weeks of admission.   A general practitioner who provides services to residents was contacted and he is very satisfied with the standard of care provided at Shalom and recommends Shalom to his patients and their families when people are requiring rest home admission.  D16.2, 3, and 4: Assessments are commenced within 24 hours and a long term care plan was completed within three weeks of admission (confirmed in review of six of six clinical records). There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. D16.5e: Six of six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen 3 monthly.   Tracer Methodology.  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:** FA |
| **Evidence:** |
| Assessment information is gathered from a variety of sources, including the resident, their family, their GP, and by using a variety of assessment tools. All care plans reflect the assessments, which are used as a basis for care planning. Residents and their family are made aware of the contents of the care plan (confirmed in discussions with six of six residents and six of six relatives and two of two registered nurses). Needs and goals are identified. An initial plan of care is commenced on admission and enhanced when new information is known (confirmed in review of six of six clinical records). All of the initial assessment data are used to inform the long term care plan. Continuing needs/risk assessments are carried out by a registered nurse. |

##### **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:** 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 1.3.5: 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:** |
| Service plans are implemented within three weeks of admission and supplemented with short term care plans where appropriate (eg, for infections) (confirmed in review of six of six clinical records and confirmed in discussions with two of two registered nurses). Care plans are comprehensive and reflect variances in resident health status. They reflect an integration of care between the residents core health team of advisors. Caregivers find the plans easy to follow (confirmed in discussions with two of two caregivers). Residents are reviewed three monthly by their GP or earlier if there are concerns. Every six months each resident is formally reviewed. Reviews are signed by the registered nurses.  D16.3k, Short term care plans are in use for changes in health status (sighted). D16.3f; Documentation in resident files show that family are involved in planning. The manager finds that family tend to be actively involved in the initial stages of admission and thereafter once satisfied with the care they tend to be happy to be less actively involved in the planning process. Every year family are invited to meet formally with the manager and RNs at a time of their choosing to discuss any matters of concern. This process is separate from the six monthly resident evaluation process and provides an additional avenue for communication. |

##### **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:** FA |
| **Evidence:** |
| The care being provided is consistent with the needs of residents documented in their plans of care (confirmed in review of six of six clinical records and in discussions with six of six residents and six of six relatives) The facility has 24/7 registered nurse cover /on call. The two RNs and the manager are responsible for the education programme, and ensure staff have the opportunity to receive updated information and follow best practise guidelines. A record of all health practitioners practising certificates and qualifications is kept. There is evidence of three monthly medical review.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed. Continence management in-service was last provided on 23 November 2012. There is only one resident who has a wound and that is a chronic leg ulcer. She has appropriate wound management in place and staff are liaising with DHB staff from the vascular service. The RNs are aware of the referral process should they require assistance from a wound specialist or continence nurse. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Activities are coordinated by an activities officer who is enrolled in the national certificate in diversional therapy. Planned activities reflect ordinary patterns of life and include, scrabble, exercises, walks, music, bingo, daily readings and newspaper reading and outings. Residents were observed participating in bowls and scrabble on the day of the audit. Residents also are offered outings to local attractions on at least a twice weekly basis. Local schools and entertainers visit and entertain residents. The service also has a close relationship with a local day care. The service has partnered with the ASB and holds cake stalls with residents manning the stall outside the ASB bank. Residents state that they enjoy the activities programme and are not coerced to join in (confirmed during interview with six of six residents). Each resident is given a copy of the weekly activities’ plan (sighted in resident’s rooms). Copies of completed resident activity profiles were sighted in six of six resident files.  D16.5d Six of six resident files reviewed identify that the individual activity profile is reviewed at the 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:** |
| Evaluations are planned to occur within three weeks of admission, three monthly by the GP and RNs and six monthly by the registered nurse with input from the GP, the registered nurse, the resident, the family and the diversional therapist. Residents and their relatives are involved in reviewing the residents care (confirmed in discussions with six of six residents and six of six relatives and two of two registered nurses). Once a year every resident is offered a family meeting as staff find that after residents have lived at the home for a while their families do not always choose to attend the six monthly evaluation meetings and this gives them another avenue to meet and communicate more formally with staff.  D16.3c: All initial care plans are evaluated by the RN within three weeks of admission. D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. |

##### **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 six resident files. The service facilitates access to other medical and non-medical services (eg, specialists at the DHB and the podiatrist). Referral documentation is maintained on resident files. All referrals are co-ordinated by the registered nurses. When the referral is to a medical specialist a letter from the GP is sent. D16.4c; The RNs and manager are aware of the processs for having residents reassessed for a higher level of care. D 20.1 Discussions with the registered nurses identified that the service has access to external specialist advice if residents require such services (the RNs liaise with the vascular team at the DHB for example a resident with the chronic leg ulcer). The majority of external advice is accessed through GPs and or staff from the DHB. Residents are given a choice of who they may wish to be referred to when there is a need for additional health and disability services. Decisions are documented. |

##### **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 service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. Discharges are coordinated by the registered nurses and the manager. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities with a transfer letter, with accompanying photocopied relevant documentation including medication charts. The registered nurses are available for any follow up or queries. The majority of ‘transfers are to the DHB. Some residents will need to be discharged to a hospital level care facility. |

##### **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:** PA Moderate |
| **Evidence:** |
| The facility uses the Douglas Pharmaceutical medico medication management system for packaging of tablets. Other medicines are dispensed in pharmacy labelled containers. The majority of medicines are supplied four weekly (unless the medicine is a short course of antibiotics or eye drops etc).  The RNs verify the medicines are correct when they are supplied and have a good system of checking and sign off, which is well documented on the pharmacy label. Discrepancies are rectified with the dispensing pharmacy. A current pharmacy agreement is in place. Policies and procedures cover prescribing, dispensing, adminstration, review, storage, disposal and medication reconciliation, and follow recognised standards and guidelines for safe medicine management practice. Medicines are prescribed by the resident’s GP and then the GPs sign a pharmacy generated medication order sheet. The medicine order sheet has been newly introduced as a corrective action to remove the practice of transcribing. The rest home deals with a large number of GPs. The RNs report they are having difficulty getting some of the GPs to sign the new medicine order forms correctly especially when some are charting new medicines, as the form is a change in layout from the previous form used. The practice at the rest home is that residents have their choice of GP. Many residents have remained with their regular GP. Residents typically will see their GPs in their GP’s practice. When they visit the GP they take their medicine forms with them to enable their GP to chart any new medicines. This means the GPs do not have to visit the home and the nurses are not transcribing telephone orders. The GPs do not visit the rest home for routine matters that can be addressed in the GP practice. This means that the RNs are usually not present when the GPs are signing the resident’s medicine chart. The RNs do not have the opportunity to intervene proactively in the event that the GP forgets to sign or date the form in the right place. A number of charting errors by GPs were noted. The errors were initially in the tracer review and detected in the review of the remaining 11 of 12 medicine charts. The sample was extended to include all 28 medicine charts. Seven residents medicine charts out of twenty eight medicine charts contained charting errors and the majority of PRN medicines were not correctly charted (refer findings are outlined in 1.3.12.1 below). Errors were highlighted to the RNs for active management.   The RNs and the majority of caregivers administer mediicines. Staff administration forms were completed accurately. However staff have been administering medicines without checking the medicine order first to determine if the order is legible and signed. Errors in the medicine charts were not detected in advance of the audit although the problem was recognised prior to audit.  A review of the controlled drugs stored on site showed that the contracted pharmacist had completed an annual stocktake of controlled drugs on 25 September 2013 rather than a six monthly review as indicated in the aged care medicines guidelines. The stocktake and reconciliation has not been recorded in the controlled drug register. Controlled drugs are stored in a locked safe in a locked cupboard in the nurse’s office. There is one controlled drug register and this was noted to be current and signed by two people and checked weekly by the RN and one other staff member.   A review of the process of warfarin management showed that the process is robust.   D16.5.e.i.2; 11 of 12 medicine charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed to indicate the review. |

##### **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:** PA Moderate |
| **Evidence:** |
| Seven residents medicine charts out of 28 medicine charts reviewed have not been correctly completed. These errors do not include the errors related to the charting of PRN medicines, which are also not correct. The seven non-PRN medicine charting errors involve three general practitioners who are associated with different general practices. The errors involve nine medicines in total including regular medicines, short course medicines. The errors include medicine orders not dated and not signed.   The majority of PRN medicines are not correctly charted in that they do not indicate the instructions to staff (i.e., the indications for use).  The contracted pharmacist completed an annual stocktake of controlled drugs on 25 September 2013 consistent with the terms of his agreement. The aged care medicine guides requires six monthly reviews. The stocktake and reconciliation has not been recorded in the controlled drug register. |
| **Finding:** |
| Staff have not correctly reconciled medicines received from the pharmacy against the medicine orders and have administered medicines without checking the medicine order to determine if the order is legible and signed. Staff have not rechecked the medicine order prior to administration of the medicine. The RNs were advised of all medicine ordering errors noted during the audit. Prescribed orders for PRN medicine orders are not always charted correctly (i.e., they do not specify the specific target symptoms, instructions for the PRN medicine use and the rationale for using the PRN medicine). There is no recorded evidence in the controlled drug register of six monthly stocktakes and reconciliations. |
| **Corrective Action:** |
| Ensure medicine orders are dated and signed by the prescriber and that PRN medicines orders specify the specific target symptoms, the instructions for the PRN medicine use and the rationale for using the PRN medicine. Ensure a six-monthly stocktake and reconciliation of controlled drugs occurs and a record of this procedure is recorded in the controlled drug register. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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:** PA Low |
| **Evidence:** |
| One resident is self-administering medicines. She has been reviewed by the RNs and her GP in July 2012, November 2012, May 2013 and November 2013. She has not been reviewed three monthly, according to the recommended practise outlined in the aged residential medicine Care Guide. |
| **Finding:** |
| One resident who is self-administering a medicine has not been formally reviewed every three months. |
| **Corrective Action:** |
| Ensure residents who self-administer medicines are formally reviewed three monthly. |
| **Timeframe (days):** 90 *(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):** 30 *(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 employs two cooks and two kitchen hands. One cooks works Monday to Friday and the other cook works on the weekends. A kitchen hand is employed Monday to Friday 10 hours a week to assist with breakfast (she also works in the laundry when she has finished in the kitchen). There is a functional kitchen which was completely renovated in June 2012. The cook has access to a gas hob and electric combi oven cooker. Nutritional needs are able to be met. There are no residents requiring special diets. One resident chooses to be gluten free and this choice is accommodated. Another requires food to be moulied but otherwise all residents have nornal diets. There is a food services manual that is comprehensive and ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. Residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. These are reviewed six monthly as part of the care plan review and are written on whiteboard in the kitchen which is visible to the cooks when serving. There is a food services manual that is comprehensive and ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. The six weekly menu is varied. The menu was last reviewed by a dietitian on 8 Oct 2013. Residents surveys describe satisfaction with the food. Meals are age appropriate and are served at times that reflect community norms. Outside of regular meal times staff will provide a nutritious snack or drink if residents are hungry or thirsty. Residents' weights are recorded on admission and monthly thereafter and there are no residents who are receiving supplementary feeding. There is special equipment available if required such as feeding cups and built up cutlery, lipped plates, non slip mats available for residents that require these items listed are per care plan documentation. There is a comprehensive cleaning schedule in place and the kitchen was clean on the day of audit. Food is procured from commercial companies. Most of the food served is prepared on site. There is ample refridgeration and freezer capacity on site and a dry goods storage area. Food is served directly from the kitchen to the adjorning dining room. Kitchen waste is picked up by a commercial operator. The fridge and freezer temperatures and the temperatures of food on delivery and at the point of serving are monitored and recorded daily and records sighted show that these are within safe limits. Six of six residents and six of six relatives interviewed stated they are very happy with the standard of meals provided.   D19.2 The cooks 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:** |
| The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Sharps and other hazardous waste are disposed of by commercial contractor. All chemicals are supplied by Ecolab/OASIS and there is a locked area for storage. There is an incident reporting system that includes investigation of incidents (although there have been none reported). Chemicals are labelled and there is appropriate protective equipment and clothing for staff. PPE is available and used. |

##### **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 building has a current building warrant of fitness, which expires 1 June 2014. One of the owners spends considerable time attending to maintenance issues and the building is well maintained In addition to the owner a maintenance person is employed to work three hours per day. He is also available on an on call basis. Both men address the planned and reactive maintanence programme. External contractors are engaged to complete work as required. Staff indicate maintanance issues in a maintenance book as they come to light. The book is checked daily during the working week and anything major on the weekend is addressed with the manager by telephone. Reactive and preventative maintenance is documented and implemented.  Electrical equipment is checked and tagged between two to five yearly by an electrician (an electrician was onsite testing on the day of audit).  Medical equipment and standing scales are calibrated (last callibration occurred 6 November 2013). The rest home does not own a hoist. Furniture and fittings in the facility have been selected with care and consideration to residents’ abilities and functioning. The bedrooms are big enough to enable safe movement within the rooms. Many of the bedrooms have doors that open to the outside, which is a well liked feature. Residents are encouraged to bring personal belongings or furnishings for their rooms. Floors are carpeted and wet areas have non slip/easy clean flooring. The grounds are very attractive with ample space for residents to mobilise safely. The owners have made considerable investment in refitting the premises in the last three years and have plans to do further investment. There is an outside deck area with shade and seating that is well maintained. All access to decks around the facility is by ramps. The site is smoke free. An van is available for use to transport residents. The van can carry up to eight residents at a time. All staff who drive have a current drivers licence and a first aid certifcate and this is recorded in their employment records. Consent to outings is included in the residents agreement. Where possible family are encouraged to accompany residents to appointments in the community and medical appointments and where this is not possible the service will endeavour to provide a staff member to accompany the resident as appropriate. The costs of transport are met by the service and those that are not are clearly outlined in the resident admission agreement.  Residents and relatives are very satisfied with the standard of the facility (confirmed in discussions with six of six residents and six of six family). One resident referred to the facility as a botique rest home that feels like she is living in a hotel.  ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs,heel protectors, lifting aids (ie, belts and slippery sams) |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All residents use communal toilets and showers which are located close to bedrooms, the lounge and dining area. There are adequate communal toilets that are easily accessible and signed. There is a separate visitors'/staff toilet available. Hot water is monitored three monthly as part of the internal health and safety audit and kept between 41 and 45 degrees (records sighted). Fixtures, fittings and flooring in the toilet/shower area have been constructed for ease of cleaning. Shower curtains are used for privacy. There are hand washing and drying facilities available in each bedroom. There is access to hand gel throughout the facility. Residents were seen using hand gel at lunch time. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate room in each resident’s bedrooms for personal belongings and room for both staff and residents. Bedrooms are of different sizes. There are two double bedrooms available. One double bedroom was occupied by a married couple and the other was occupied only by one person. There is adequate space in residents' bedrooms. Many bedrooms have external doors some of which open directly onto the deck. Residents' rooms all have single doors in two wings and double doors in the other two wings. The only time residents are required to be transferred from their bedrooms is in an emergency situation and the registered nurse confirms that ambulance gurneys have no problem with access. |

##### **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 are two lounge areas to allow for activities, resident relaxation and to provide privacy when having visitors. These are bright and airy and allow freedom of movement for all residents including those using mobility aids. There are two dining areas which adjorn each other, giving the feel of being one large dining room. Residents also have access to external areas for relaxation. |

##### **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:** PA Low |
| **Evidence:** |
| The service has in place policies and procedures for effective management of laundry and cleaning practices. One cleaner is employed 37.5 hours a week. The cleaning of the facility is monitored through the internal audit programme (last internal audit was completed in June 2013) and the results were discussed at the staff meeting. The cleaner has a dedicated storage cupboard for chemicals and equipment when not in use. One person is employed to manage the laundry 27.5 hours a week. She works Monday to Friday from 9.15 to 3 pm. Non-personal laundry is cleaned on the weekend by caregivers. There is a laundry routine and policy available that includes the use of personal protective equipment, handling of linen, waste disposal and with hazard controls. Two large containers of chemicals are being used in the laundry and not able to be stored securely due to their size and the size of the storage cupboard. Other smaller bottles of chemicals are able to be stored securely in the designated space provided. Laundry processes are monitored for effectiveness as part of the internal audit programme. . |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two large containers of chemicals are used in the laundry and not able to be stored securely. Other smaller bottles of chemicals are able to be stored securely. |
| **Finding:** |
| All chemicals in the laundry were not able to be stored securely as the containers that they are stored in are too large to be stored in the secure storage cupboard. |
| **Corrective Action:** |
| Ensure all chemicals are stored securely in the laundry |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are established emergency response policies and procedures and an emergency plan. There is 24 hour registered nurse on call cover to provide appropriate response to clinical emergencies. Staff are trained in fire safety and evacuation as part of orientation and at the six monthly fire evacuation drills. The most recent occurred on 6 June 2013. The fire evacuation scheme has been approved by the NZ Fire Service (letter sighted dated 24 February 2000). Fire and emergency equipment is checked monthly by external contractors. The fire system and emergency lighting was tested by the contractor on the day of the audit. Senior staff (including senior caregivers) have current first aid certificates. A list of residents (including identification of those who need assistance) and a fire jacket are kept at each assembly area.  Emergency lighting, gas cooking, a barbecue and gas bottle, under floor gas heating and additional blankets and food supplies (food is dated) are available in the event of a power failure. The facility has a water tank with 25000 litre capacity. Emergency supplies including batteries, torches, a radio and pandemic supplies are stored and checked regularly. Call and emergency bells are available in all bedrooms, toilets and bathrooms. Maintenance and repairs are completed by external contractors.   Security policies and procedures are documented and implemented by staff. Afternoon and night staff ensure all outside doors and windows are securely locked. Two staff sign the security checklist when security procedures are completed. There is security lighting for after dark. The building is alarmed and is connected to an external security firm. External doors and windows are locked at night. |

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

##### **Criterion 1.4.7.5 (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:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents’ bedrooms have an external window and are well lit by natural light. There is adequate external light in communal areas. The building is ventilated by opening windows and doors and by the under floor ventilation. The ventilation system provides air-conditioning in summer. The temperatures in the building are monitored automatically by the ventilation system. |

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint policy applicable to the provision of rest home services. The policy includes definitions and classifications of restraint and enablers, procedures for restraint authorisation, assessment, types of restraint approved in the facility, training, monitoring and review/evaluation. There are associated forms to support the policy. Staff attended training on challenging behaviour on 6 July 2012 and on restraint in September 2012.   No residents were using enablers or restraint at the time of the audit. |

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

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

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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

##### **Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)**

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

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

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

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

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

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

##### **Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)**

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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

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

Services use restraint safely

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

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

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The responsibility for infection prevention and control (IPC) is clearly defined in policy. There is an infection prevention and control policy and procedure manual which is readily accessible to all staff. There are clear lines of accountability for IPC matters in the organisation. Infection prevention and control is overseen by both registered nurses with one of the two registered nurses takes the lead responsibility. In practice both registered nurses work together on IPC. The IPC coordinator is responsible to the manager who is responsible to the owners. There is an established infection prevention and control programme which is reviewed annually (last reviewed 4 June 2013). The infection prevention and control programme its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service and is linked into the incident reporting system. Staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. There are warning notices on the front door of the facility. Visitors are warned by notices on the front door. IPC is an agenda item at staff meetings. There is discussion and reporting of infection prevention and control matters and the consequent review of the programme. Minutes are available for staff. Regular internal audits occur which include hand hygiene, infection prevention and control practises, laundry and cleaning and spot checks. Annual education is provided for all staff with external in-services provided by local providers (last provided September & October where staff were shown a video on IPC). The infection prevention and control coordinator collates the monthly record of infections data every month and provides a report to manager and staff. Any emergent issues are informed promptly. The infection prevention and control coordinator and resident GP are promptly notified of any positive pathology that is identified as an infection. Any notifiable disease or serious outbreaks are notified to the appropriate authorities. There is an RN available 24/7 on call for emergent issues. There have been no outbreaks of disease since an outbreak of Norovirus in 2012. |

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

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

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

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

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

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

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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 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 programme is managed by one registered nurse with assistance from the other registered nurse and assistance from a caregiver who helps with data entry. The IPC and the other registered nurse have access to GPs for advice, as well as laboratory staff and the IPC specialist staff from the DHB. Internal IPC audits occur three monthly. There are adequate resources to implement the infection prevention and control programme for the size and complexity of the organisation. |

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection prevention and control policy and procedures manual which includes policies and procedures appropriate to for the size and complexity of the service. The infection prevention and control policy was last reviewed in September 2013 and reflects the current standard 8134:2008.  D 19.2a: Infection prevention and control policies include (a) Hand hygiene; (b) Standard precautions; (c) Transmission-based precautions;(d)Prevention and management of infection in service providers; (e) Antimicrobial usage; (f) Outbreak management; (g) Cleaning, disinfection, sterilisation, and reprocessing of reusable medical devices (if applicable) and equipment; (h) Single use items; and (i) Renovations and construction. |

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a commitment to the on-going education of staff and residents. This is facilitated by the infection prevention and control coordinator with expert support from external providers who provide the service with current and best practise information. IPC staff from the DHB provide education from time to time. Staff from the DHB provided education on Norovirus and other IPC matters on 7 May 2013. A video on IPC was shown to staff in September 2013. The video was seen in small groups and given to individuals to watch. A record of attendance at all infection prevention and control training is maintained. Caregiver competency was assessed on 4 March 2013 and 18 staff members were assessed as competent. Residents are educated on IPC on an ‘as needs’ basis. Residents were observed using hand gel in the dining room to clean their hands prior to eating lunch. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Surveillance for infection is an integral part of the infection prevention and control programme and is described in policy. Monthly infection prevention and control data are collected on all infections by both registered nurses and collated. All infections are entered on to an infection register. The data are monitored and evaluated. Outcomes and actions are discussed at the infection prevention and control, staff and management meetings. |

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

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

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

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

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

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