

# Radius Residential Care Limited - Radius Arran Court Home & Hospital

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Current Status: 3 December 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

Radius Arran Court is part of the Radius Residential Care Group. Radius Court cares for up to 102 residents requiring rest home and hospital level care. On the day of the audit there were 56 residents receiving hospital level and 45 receiving rest home level.

The facility manager has many years of aged care management experience. She has been at the service for three years and is supported by a competent clinical manager. She is also supported by the Radius regional manager.

This audit has identified improvements required around aspects of medication management, care planning, wound management and corrective action planning.

## Audit Summary as at 3 December 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

Indicator	Description	Definition
	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 3 December 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 3 December 2013

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.
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### Continuum of Service Delivery as at 3 December 2013

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.
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### Safe and Appropriate Environment as at 3 December 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 3 December 2013

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.
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## Infection Prevention and Control as at 3 December 2013

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.
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## Audit Results as at 3 December 2013

### Consumer Rights

Arran Court displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights (the Code). Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of 'the Code'. Staff and residents are aware of the complaints process. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activity and members of the community visit the facility. Resident satisfaction surveys confirm that residents are satisfied that their rights, privacy and cultural needs are respected. Residents have the opportunity to participate in a regular residents' meeting.

### Organisational Management

Radius Arran Court is managed by a facility manager who is a registered nurse. The Radius quality philosophy is expressed and implemented in a range of facility based data that is collected and monitored. The programme includes accident and incident reporting, infection control surveillance, internal audits, review of policies and procedures and hazard identification and management. Oversight is provided at monthly continuous quality improvement meetings. Outcomes are shared with the staff. Corrective actions are issued when areas are identified as requiring improvement, and as part of the audit and accident/incident reporting process. There is an improvement required around internal audits.

A set of quality indicators are used by each Radius aged care facility to monitor trends and to benchmark against other Radius facilities. The facility manager reports weekly to the regional manager on a range of quality related activity. Risks are identified and addressed and include those related to clinical care, human resources, health and safety, the environment and financial management. These are reviewed annually in line with the end of the financial year at a facility and national level. Residents and their family members are involved in decisions relating to care provision.

Documented procedures are followed for the recruitment, orientation and monitoring of staff performance. Staff training takes the form of on-going in-service, attendance at external courses for the registered nurses and participation of caregivers in the Aged Care Education (ACE) programme. Regular in-service training for staff is well attended.

Staffing levels follow documented acuity levels and meet ARRC requirements.

### **Continuum of Service Delivery**

The service has an admission policy and process. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents and family members confirmed the admission process and that the agreement was discussed with them. A registered nurse is responsible for each stage of service provision.

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. There is an improvement required around care planning. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration. Resident files include notes by the GP and allied health professionals. There is also an improvement required around wound management.

Medication policies reflect legislative requirements. Education and medicines competencies are completed by the clinical manager and health care assistants responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around controlled drug checks, prescribing documentation for as required medications and medication administration.

The activities programme is facilitated by a recreational coordinator. The activities programme provides varied options of activities enjoyed by the residents. Each resident has an individualised plan. Community activities are encouraged, resident outings are arranged on a regular basis.

All food is cooked on site. All residents' nutritional needs are identified, documented. Meal choices are available. Meals are well presented and the menu plans have been reviewed by a dietitian.

### **Safe and Appropriate Environment**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme.

There are appropriate systems in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

## **Restraint Minimisation and Safe Practice**

The restraint policy and procedure states that the use of restraint is a last resort only. The policy describes methods of restraint permitted within Radius facilities including the use and definition of enablers permitted. The four restraint coordinators (all registered nurses) are trained in restraint management. A process is in place to ensure that prior to the use of restraint all measures are taken to consider other options. The application of restraint requires formal approval after discussion with the resident, family and the general practitioner. Procedures are implemented to ensure that the use of restraint is recorded, monitored and evaluated at appropriate intervals, including the use of a restraint monitoring form. Staff are trained in the management of challenging behaviours and restraint.

## **Infection Prevention and Control**

The infection control coordinator position is held by a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to the infection control meeting and the quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

# HealthCERT Aged Residential Care Audit Report (version 3.91)

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## 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

<b>Legal entity name:</b>	Radius Residential Care Ltd		
<b>Certificate name:</b>	Radius Arran Court Rest Home & Hospital		
<b>Designated Auditing Agency:</b>	HDANZ		
<b>Types of audit:</b>	Certification		
<b>Premises audited:</b>	Radius Arran Court Rest Home & Hospital, 85 McLeod Road, Te Atatu South, Auckland		
<b>Services audited:</b>	Rest home and hospital		
<b>Dates of audit:</b>	<b>Start date:</b> 3 December 2013	<b>End date:</b> 4 December 2013	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			101

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	15	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	30	<b>Total hours off site</b>	12
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	45	Total audit hours off site	20	Total audit hours	65
Number of residents interviewed	11	Number of staff interviewed	21	Number of managers interviewed	2
Number of residents' records reviewed	11	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	22	Total number of staff (headcount)	96	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Wednesday, 8 January 2014

## Executive Summary of Audit

### General Overview

Radius Arran Court is part of the Radius Residential Care Group. Radius Court cares for up to 102 residents requiring rest home and hospital level care. On the day of the audit there were 56 residents receiving hospital level and 45 receiving rest home level.

The facility manager has many years of aged care management experience. She has been at the service for three years and is supported by a competent clinical manager. She is also supported by the Radius regional manager.

This audit has identified improvements required around aspects of medication management, care planning, wound management and corrective action planning.

### Outcome 1.1: Consumer Rights

Arran Court displays posters and pamphlets describing the Code of Health and Disability Services Consumers' Rights (The Code). Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of 'The Code'. Staff and residents are aware of the complaints process. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are trained in resident rights and apply these in practice. Residents are encouraged to participate in community activity and members of the community visit the facility. Resident satisfaction surveys confirm that residents are satisfied that their rights, privacy and cultural needs are respected. Residents have the opportunity to participate in a regular residents' meeting.

### Outcome 1.2: Organisational Management

Radius Arran Court is managed by a facility manager who is a registered nurse. The Radius quality philosophy is expressed and implemented in a range of facility based data that is collected and monitored. The programme includes accident and incident reporting, infection control surveillance, internal audits, review of policies and procedures and hazard identification and management. Oversight is provided at monthly continuous quality improvement meetings. Outcomes are shared with the staff. Corrective actions are issued when areas are identified as requiring improvement, and as part of the audit and accident/incident reporting process. There is an improvement required around internal audits.

A set of quality indicators are used by each Radius aged care facility to monitor trends and to benchmark against other Radius facilities. The facility manager reports weekly to the regional manager on a range of quality related activity. Risks are identified and addressed and include those related to clinical care, human resources, health and safety, the environment and financial management. These are reviewed annually in line with the end of the financial year at a facility and national level. Residents and their family members are involved in decisions relating to care provision.

Documented procedures are followed for the recruitment, orientation and monitoring of staff performance. Staff training takes the form of on-going in-service, attendance at external courses for the registered nurses and participation of caregivers in the Aged Care Education (ACE) programme. Regular in-service training for staff is well attended.

Staffing levels follow documented acuity levels and meet ARRC requirements.

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

The service has an admission policy and process. Service information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents and family members confirmed the admission process and that the agreement was discussed with them. A registered nurse is responsible for each stage of service provision. .

The sample of residents' records reviewed provide evidence that the provider has systems to assess, plan and evaluate care needs of the residents. There is an improvement required around care planning. A registered nurse assesses and reviews residents' needs, interventions, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration. Resident files include notes by the GP and allied health professionals. There is also an improvement required around wound management.

Medication policies reflect legislative requirements. Education and medicines competencies are completed by the clinical manager and health care assistants responsible for administration of medicines. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted.

There is an improvement required around controlled drug checks, prescribing documentation for as required medications and medication administration.

The activities programme is facilitated by a recreational coordinator. The activities programme provides varied options of activities enjoyed by the residents.

Each resident has an individualised plan. Community activities are encouraged, resident outings are arranged on a regular basis.

All food is cooked on site. All residents' nutritional needs are identified, documented. Meal choices are available. Meals are well presented and the menu plans have been reviewed by a dietitian.

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

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme.

There are appropriate systems in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

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

The restraint policy and procedure states that the use of restraint is a last resort only. The policy describes methods of restraint permitted within Radius facilities including the use and definition of enablers permitted. The four restraint coordinators (all registered nurses) are trained in restraint management. A process is in place to ensure that prior to the use of restraint all measures are taken to consider other options. The application of restraint requires formal approval after discussion with the resident, family and the general practitioner. Procedures are implemented to ensure that the use of restraint is recorded, monitored and evaluated at appropriate intervals, including the use of a restraint monitoring form. Staff are trained in the management of challenging behaviours and restraint.

### Outcome 3: Infection Prevention and Control

The infection control coordinator position is held by a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to the infection control meeting and the quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

### Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	46	0	1	3	0	0
Criteria	0	97	0	1	3	0	0

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

### Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is not consistently analysed.	Ensure all quality data is analysed.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Four of eleven care plans sampled do not reflect interventions for all current needs of the resident.	Ensure all care plans reflect interventions for all current needs.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)Nine of 21 wounds do not have a timeframe for the next review documented. (ii) Two of 21 wounds have not been reviewed within stated timeframes.	(i)Ensure that all wound management plans have timeframes for review date. (ii) Ensure that all wounds are reviewed within stated timeframes	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	(i)Nine of 22 medication charts sampled have PRN medications charted with no frequency or maximum dose charted. (ii) Five of 22 medication charts sampled have regular medications charted that have not always been signed as administered.	(i)Ensure all prn medication have frequency and maximum dosage charted medications are signed for. (ii) Ensure that all regular medication is administered and signed for. (iii) Ensure that the CDs are checked weekly.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				(iii) In hospital B and the rest home the weekly CD checks have not always occurred.		

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is an implemented code of rights policy and procedure. Discussions with six of six health care assistants, one enrolled nurse (ENs) and four registered nurses (RNs) identified their familiarity with the code. Interviews with 11 of 11 residents (five from the rest home and six from the hospital) and five of five relatives (three from the hospital and two from the rest home) confirm that the service is provided in line with the code of rights. Code of rights/advocacy/complaints training was last provided in November 2013 (37 attended).

### 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.

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

## 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

**Attainment and Risk:** FA

**Evidence:**

The service provides information to residents that includes the code of rights, complaints and advocacy information. There is access interpreter services if required. Information is given to next of kin or Enduring Power of Attorney (EPOA) to read to and/or discuss with the resident. Interviews with 11 of 11 residents (five from the rest home and six from the hospital) and five of five relatives (three from the hospital and two from the rest home) identify that they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints. Posters describing the Code are displayed in each wing in English, Maori and in sign language. Pamphlets are available in the reception area and outside each nurses' station.

Monthly resident/relative meetings (minutes sighted) are held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets are included in the information pack and are also available in the reception area and outside each nurses' station. Posters are placed at reception and in each wing with the name, photograph and contact details of the health advocate. The service has an advocacy policy that includes a definition of advocacy, objectives and process/procedure/guidelines.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and H&D Commission information.

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Criterion 1.1.2.4 (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.

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

#### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has policy aligned with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy &amp; dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retain the confidentiality of client records. The employee handbook addresses confidentiality of information and the importance of non-disclosure.</p> <p>Discussions with 11 of 11 residents (five from the rest home, six from the hospital) and five relatives (three from the hospital and two from the rest home) confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.</p> <p>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.</p> <p>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.</p> <p>The spiritual and religious beliefs policy guides practice from an organizational perspective. Interdenominational services are held fortnightly. Contact details of any spiritual/religious advisors are available to staff. Catholic communion is available to residents weekly. Two of the 11 residents interviewed state that they receive communion. Religious dietary requirements identified through assessment and care planning and met as required. All relatives interviewed (three from the hospital and two from the rest home) and 11 of 11 residents (five from the rest home and six from the hospital) confirm the service is respectful.</p>

A client satisfaction survey is carried out annually to gain feedback. In the survey completed in July 2013, respondents confirm that their privacy and dignity was respected.

D4.1a: Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

The information pack provided to residents and their families includes the home's philosophy of care. Discussions with 11 residents (five from the rest home, six from the hospital) confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they have adequate rights to choose within the constraints of the service.

Eleven of 11 care plans reviewed (six hospital and five rest home) identified specific individual likes and dislikes.

The abuse & neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Training is an annual requirement. All facilities are required to have a copy of the "Elder Abuse & Neglect - a Handbook for those working with Elder Abuse" from Age Concern. Code of rights training was last conducted in November 2013 and abuse and neglect training occurred in May 2013 with 46 staff attending. Discussions with management and six healthcare assistants, four registered nurses, one enrolled nurse, the clinical manager and the three activities coordinators reported no incidents of abuse/neglect.

D4.1a Resident files reviewed identify 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.

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

#### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

**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.

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

### 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

**Attainment and Risk:** FA

**Evidence:**

There is a specific Maori Health care plan and a culturally safe care policy. Discussions with six of six health care assistants, one enrolled nurse and four registered nurses confirm an understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. In addition there is a Maori care plan available if the individual resident wishes. The Maori resident at Arran Court has a documented Maori health plan. There is information and websites provided within the Maori Health Plan to provide quick reference and links with local Maori Healthcare Providers regionally within New Zealand.

D20.1 i: The service also utilises the health advocate as a Maori cultural advisor.

The Maori Health plan states that staff training sessions will be provided two yearly for all staff. Cultural safety training was provided in March and April 2013 (48 attended). The service has documentation relating to culturally appropriate responses in particular settings. Interview with two Maori residents (one rest home and one hospital) verifies that their cultural needs are met and tikanga is observed.

The Maori health care plan includes reporting on significant others to be involved in care such as iwi affiliations and advocates. Interviews with six of six health care assistants, one enrolled nurse and four registered nurses confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

## 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

**Attainment and Risk:** FA

**Evidence:**

Care planning includes consideration of spiritual, psychological and social needs. Eleven of 11 residents (five from the rest home, six from the hospital) state that they are involved in the identification of their spiritual religious and or cultural beliefs. Five of five relatives (three from the hospital and two from the rest home) state during interview that they felt valued and were consulted and kept informed. Family involvement is encouraged e.g. invitation to facility functions. Care planning includes consideration of spiritual, psychological and social needs. In the resident survey completed in July 2013, respondents indicate that they are satisfied that their cultural and spiritual/religious needs are being met.

Employees reflect a range of ethnicities as reflected among the residents, including Maori, Pasifika and Asian.

D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by six of six health care assistants, one enrolled nurse and four registered nurses.

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.

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

There is an implemented discrimination and harassment policy that includes all aspects of this criterion. There is a staff policy in relation to gifts and gratuities and the management of external harassment. The following policies also support keeping residents safe from exploitation: code of resident's rights, abuse and neglect, and complaints. Annual training is provided to staff across a number of topics such as: code of rights (November 2013) and communication (September 2013). Eleven residents (five from the rest home, six from the hospital) interviewed confirm they were not exposed to exploitation.

The staff employment handbook and orientation package includes a code of behaviour. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. There are clear ethical and professional standards and boundaries within job descriptions.

Interviews with six of six health care assistants, one enrolled nurse and four registered nurses, the clinical manager and the four activities coordinators verify that they have an understanding of professional boundaries.

### 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.

**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 1.1.8: 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

**Attainment and Risk:** FA

**Evidence:**

The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the operations management team at an organizational level. Advice is sought from clinicians when clinical policies are reviewed. The good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The human resource manual addresses pre-employment procedures, the requirement to attend orientation and on-going in-service training.

Arran Court's facility manager oversees the internal audit and in-service education programmes with support from senior staff. Staff are informed when external training is available and financial support is considered. There is support available for those wishing to pursue post-graduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines. There is organizational membership to Bug Control for infection control updates / training and expert advice.

There are daily meetings between the management team (the facility manager, the assistant to the facility manager the clinical manager and the administration manager, monthly staff and monthly resident meetings.

Eleven of 11 residents (five from the rest home, six from the hospital) and five of five relatives (two from the rest home, three from the hospital) interviewed spoke positively about the care and support provided. Six of six healthcare assistants, two registered nurses, the clinical nurse leader and the activities assistant have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education.

A2.2: Services are provided at Arran Court that adheres to the Health & Disability Services Standards (2008). There is an implemented quality improvement programme that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

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

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

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

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

Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with ... health care assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, photographs and provision of care. All 11 resident files (five from the rest home and six from the hospital) reviewed has signed consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in 11 resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented.

D13.1: There were 11 admission agreements sighted and all had been signed on the day of admission.

D3.1.d: Discussion with five of five relatives (three from the hospital and two from the rest home) identified that the service actively involves them in decisions that affect their relative's lives.

There is an open disclosure policy. The communication with resident's policy includes procedures to ensure that staff communicates well with residents and family members. There are monthly resident/relative meetings facilitated by the facility manager allowing residents/relatives to raise issues. Eleven of 11 residents (five from the rest home, six from the hospital) state that they were welcomed on entry and were given time and explanation about services and procedures.

Ten incident reports were reviewed across the service. All recorded family notification. Five of five relatives interviewed (two from the rest home, three from the hospital) confirm that they are notified of any changes in their family member's health status. The clinical manager, who investigates incidents, verifies that there are processes in place to support family notification of events.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: All five relatives state that they are informed when their family members health status changes.

The facility has an interpreter policy to guide staff in accessing interpreter services. Staff represent a range of ethnicities and languages including Maori, Pasifika and Asian. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

D11.3 The information pack is available in large print. This can be read to residents.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

**Attainment and Risk:** FA

**Evidence:**

Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with six health care assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements and consent for transporting, photographs and provision of care. All 11 resident files (five from the rest home and six from the hospital) reviewed has signed consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in 11 resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented.

D13.1: There were 11 admission agreements sighted and all had been signed on the day of admission.

D3.1.d: Discussion with five of five relatives (three from the hospital and two from the rest home) identified that the service actively involves them in decisions that affect their relative's 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

### 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

**Attainment and Risk:** FA

**Evidence:**

There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and advocacy pamphlets are available at reception and nurses' stations. A notice with the health advocate's name, photograph and contact information is displayed in the reception area and in each wing.

D4.1e; The resident file includes information on residents family/whanau and chosen social networks

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussion with five of five relatives (two from the rest home, three from the hospital) identifies that the service provides opportunities for the family/EPOA to be involved in decisions.

#### 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.

**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 1.1.12: 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

**Attainment and Risk:** FA

**Evidence:**

The client information pack states that visiting can occur at any reasonable time. Interviews with 11 of 11 residents and five of five relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans and there is a family communications/contact sheet in resident files where staff document when family have been contacted.

The service has strong community support and engagement. Entertainers were observed in the facility on the second day of the audit.

D3.1.e Discussion with 11 residents and five relatives verifies they are supported and encouraged to remain involved in the community and with external groups. One resident interviewed goes shopping, some go on the organised bus outings or outings with visitors and another assists with the maintenance of the gardens in the facility.

D3.1h: Discussion with five of five families that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints policy and procedure states that clients/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via the suggestion box. The latter two are available in the reception area.

A client's complaint procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that complaints process is to be visible and available in public areas.

Interviews with 11 residents (five from the rest home, six from the hospital) and five of five relatives (two from the rest home, three from the hospital) verify that they are familiar with the complaints procedure and state that concerns /complaints are addressed.

The complaints log/register includes the date of the incident, name of the complainant, nature of the complaint, summary of the complaint and the outcome. Each complaint is signed off when completed. All complaints include a corrective action plan and documentation related to the investigation and resolution, including communication with the complainant/s. the most recent complaint was received in November 2013 related to the care of personal belongings. There are no outstanding complaints.

D13.3h. A 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.

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

**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.

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

**Outcome 1.2: Organisational Management**

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

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

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

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

### Attainment and Risk: FA

#### Evidence:

Arran Court is part of the Radius Residential Care Group. Arran Court care for residents requiring hospital and rest home level care. On the day of the audit there were 45 residents receiving rest home level care and 56 receiving hospital level care.

The facility manager reports monthly to the regional manager on a range of operational matters in relation to Arran Court including strategic and operational issues, incidents and accidents, complaints, health and safety. Radius mission statement states that:

"We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"

Radius has an organisational philosophy, which includes vision, mission statement & objectives including quality/risk management framework & process policy. Annual business quality/risk management plans are in place (sighted for 2013). A quality/risk management plan for 2013 has been developed for Radius Residential Care and

Arran Court has developed site specific objectives including:

1. Clinical and Operational key performance indicators
2. Clinical effectiveness
3. Consumer participation
4. Workforce effectiveness
5. Risk management
6. Taking ownership of the business and services provided
7. Effective financial leadership and management
8. Cost containment and reduction.

The service has a documented structure that supports continuity of management and care delivery.

The organisation provides annual conferences for their managers and annual regional conferences.

The Radius Arran Court business plan April 2012 to March 2015 is linked to the Radius business plan and DHB plans. The plan describes the core values, related strategies and benchmarking processes. Key objectives have associated goals and targets for 2012 to 2013. A review occurs annually. The mission statement is included in information given to new residents.

The service is managed by a facility manager who has been in the position since January 2011 and is a registered nurse with a current practising certificate. She also has a bachelor of education degree. A job description describes the key accountabilities, result areas, performance measures and purpose of her role. The most recent performance appraisal was completed on 20 August 2013.

ARC, D17.3di (rest home), D17.4b (hospital), The manager has maintained at least eight hours annually of professional development activities related to managing a hospital. She has completed in excess of eight hours professional development in 2013 including attendance at the Radius conference, participation in the mini-conference and attendance at a facility managers' forum and a conference held in November 2013 by the New Zealand Aged Care Association.

There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and service register. These are paper based files.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whanau on admission, for permission to display the resident's name and taking of photographs.

D7.1 Entries are legible, dates and signed by the relevant caregiver or RN including designation

Care plans and notes are legible and where necessary signed and dated. Policies contain service name. All resident records contain the name of resident and the person completing the form/entry.

Individual resident files kept demonstrate service integration that also contains GP notes and the allied health professionals and specialists records if applicable.

Communication with families is documented in the communication form and this was well used in 11 of 11 files reviewed.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

**Attainment and Risk:** FA

**Evidence:**

During the temporary absence of the facility manager, Arran Court is managed by the clinical manager, who is a registered nurse, with support from the Arran Court management team and the regional manager.

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identifies that the service has operational management strategies and a QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

#### **Evidence:**

There are organisational policies to guide each facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable. The quality system is established at Arran Court. Staff have designated portfolios including incidents and accidents, training, restraint, health and safety and infection control. Interviews with six of six health care assistants, one enrolled nurse and four registered nurses confirmed that quality data is discussed at monthly staff meetings (staff and RN meeting minutes reviewed). The facility manager advised that she is responsible for providing oversight of the quality programme. There is also a monthly quality meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.

The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Assessment tools completed linked with resident care plans and were reviewed six monthly. There is an annual staff training programme that is implemented and based around policies and procedures. Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy.

D5.4 The service has the appropriate policies and procedures to support service delivery;

There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified at interview with six of six health care assistants, one enrolled nurse and four registered nurses). Staff have access to manuals (nurse's stations and staff room). Policies are up to date and are located electronically on 'P' drive.

Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, staff notice boards.

a) There are monthly accident/incident reports completed by the facility manager that break down the data collected across the service.

b) The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints.

c) There is an infection control data collection form which records all infections for each month. Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.

d) Health and safety is an agenda item of the staff meeting. Any new hazards are discussed.

e) Advised that the restraint committee report through the quality and restraint meetings, feedback is provided to staff and registered nurse meetings. Restraint use is also fed back to the organization through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings

Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Arran Court by the facility manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, infection control, medications,

code of rights, informed consent, vehicle compliance and restraint. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and discussed at the quality meeting and staff are informed through the registered nurses and staff meetings. Quality data are not consistently analysed. For example, a medicine audit was completed on 18 October 2013. Five registered nurses were asked to complete the audit. There is no evidence that the results are collated. Similarly, a restraint audit was completed by 14 individual registered nurses in July 2013. The results were collated for each individual audit but the total results were not collated. This is an area requiring improvement. Minutes of RN meetings verified audit results are discussed.

Radius policy informs a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans were developed for incident reports (sighted) and all audits where there has been less than 95% conformity.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g: Falls prevention strategies such as aggregating data monthly that includes considering time of occurrence

There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency.

There is an organisational risk register that includes identified risk and risk rating, identified action to prevent or minimize risk and persons responsible and covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risk. Radius has terms of reference for the national and facility based H&S committees that defines membership to include healthcare assistants and a household representative. Radius achieved tertiary level ACC Workplace Safety Management Practices to 31 August 2014 (for a two year period). Arran Court has a hazard register (June 2013).

#### **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.

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

**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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Arran Court by the facility manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, infection control, medications, code of rights, informed consent, vehicle compliance and restraint. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and discussed at the quality meeting and staff are informed through the registered nurses and staff meetings.
<b>Finding:</b> Quality improvement data is not consistently analysed.
<b>Corrective Action:</b> Ensure all quality data is analysed.
<b>Timeframe (days):</b> 90 (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.

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

**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.

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

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure.  When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN will undertake an initial assessment. The RN will notify family and General Practitioner (GP) as required. The clinical manager collects incident reports daily and reviews both the incident and actions taken. Where the action taken is not considered to have been comprehensive, the clinical nurse leader will investigate and escalate to the facility manager. Ten incident forms sampled evidence detailed investigations and corrective action plans following incidents. Monthly data is taken to the risk management and restraint meeting. The six healthcare assistants and two registered nurses interviewed could describe the process for management and reporting of incidents and accidents.  D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken (falls monthly summary's sighted) and outcomes are discussed at all meetings - management, quality, and staff meetings.

Ten incident forms were reviewed across the service and clinical actions were well documented. Actions taken to minimise risk to individual residents are recorded. As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There was evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, and fractures), skin tears, medication and pressure areas.

Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken (falls monthly summaries sighted) and outcomes are discussed at all meetings - management, Continuous Quality Improvement (CQI) and staff meetings. Monthly data is taken to CQI meeting and staff meetings. The six of six health care assistants, one enrolled nurse and four registered nurses interviewed could describe the process for management and reporting of incidents and accidents.

D19.3c Discussions with the service (regional manager, and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. A norovirus outbreak was reported to personnel at the ADHB on 13 January 2013. Staff training also occurred on this day. An outbreak case log was documented and an action plan was developed including the use of a different disinfectant as advised by ADHB. Daily notifications were sent to the ADHB until the outbreak ceased on 18 January 2013.

#### **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.

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

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Arran Court employs a facility manager, a clinical manager, sixteen additional registered nurses and three enrolled nurses. All have current practising certificates. Copies of current practising certificates are also kept for the four general practitioners that visit the facility, three pharmacists, the dietician, podiatrist and physiotherapist. All registered nurses have current first aid certificates. There are 49 healthcare assistants. Ten have completed the Aged Care Education (ACE) programme, 18 are enrolled in the ACE programme, 10 are registered nurses trained overseas and one has completed the national certificate in support of the older person. Hard and electronic records are kept of all training completed by each employee.</p> <p>Ten staff files were reviewed (one kitchen, one housekeeper, one activities coordinator, five healthcare assistants and two registered nurses). The recruitment process includes a written application, an interview, police checks, visa evidence (as required) and referee checks. All have a documented orientation and current performance appraisal.</p> <p>The organisation has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new healthcare assistant is buddied for three shifts with an experienced healthcare assistant. The employee handbook includes hard copy information about key service delivery areas. Interview of six of six healthcare assistants and registered nurses confirms that the orientation process is comprehensive and includes a period of being buddied.</p> <p>The service has an internal training programme directed by head office that addresses key areas of service delivery including challenging behaviour, resident rights,</p>

abuse and neglect. Attendance records are kept. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. All sessions include a quiz which is used at Arran Court to embed information from the sessions provided. In addition to training requirements there are healthcare assistant competencies (hand washing, manual handling, medicines, and restraint) with a tracking sheet in place to monitor requirements. A log documents the date of each employee's competency check.

D17.7d: RN competencies include: hand washing, Niki T34 syringe driver, restraint, medicine and oxygen.

#### **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.

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

#### **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.

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

**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.

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

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager and clinical nurse leader, both registered nurses work full time. Staff turnover is low. The six healthcare assistants, four registered nurses, one enrolled nurse, the clinical manager and the three activities coordinators interviewed stated that there is adequate staffing to manage their workload on any shift. The GP was interviewed and confirmed that staffing is appropriate to meet the needs of residents. Eleven of 11 residents (five from the rest home and six from the hospital) and five of five relatives (three from the hospital and two from the rest home) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent and friendly. An acuity and clinical staffing ratio policy is in place that includes a documented rationale for staffing the service. Staffing rosters were sighted. These meet the needs of different shifts. The facility manager and the clinical manager, both registered nurses, work full time each weekday. The quality initiative plan states that "Arran Court has employed more registered and enrolled nurses to ensure that there is a registered nurse or enrolled nurse in each hospital area at night working with the healthcare assistants. This is verified in rosters. On call is shared by the clinical manager, a registered nurse and the facility manager.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## 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

**Attainment and Risk:** FA

**Evidence:**

There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and service register. These are paper based files.  
Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whanau on admission, for permission to display the resident's name and taking of photographs.  
D7.1 Entries are legible, dates and signed by the relevant caregiver or RN including designation  
Care plans and notes are legible and where necessary signed and dated. Policies contain service name. All resident records contain the name of resident and the person completing the form/entry.  
Individual resident files kept demonstrate service integration that also contains GP notes and the allied health professionals and specialists records if applicable.  
Communication with families is documented in the communication form and this was well used in 11 files reviewed.

### 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.

**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 1.2.9.7 (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.

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

**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.

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

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

All records pertaining to individual consumer service delivery are integrated.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs Assessment Service Coordination (NASC) assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the residents level of care requirements. There is a comprehensive information pack provided to all residents and their families for rest home, hospital and acute GP care. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. Eleven residents (five from the rest home and six from the hospital) and five of five relatives (three from the hospital and two from the rest home) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Eleven resident files (five from the rest home and six from the hospital), were reviewed. All eleven had NASC approval and signed service agreements.

D13.3: The admission agreement reviewed aligns with a) - k) of the ARC contract.

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a declining entry section in the admission procedure. The service records document the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

There is a policy and process that describe resident's admission and assessment procedures.

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.

Activity assessments and the activities sections care plans have been completed by the diversional therapist.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment, c) continence assessment d) cultural assessment, e) skin assessment, f) and nutritional assessment and g) pain assessment.

Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

All eleven files identified integration of allied health including district nurses, hospice, dietitian, oncology, DHB nurse specialist, physiotherapy and podiatry. The GP interviewed spoke very positively about the service and describes effective communication processes.

D16.2, 3, 4: The eleven resident files reviewed (five from the rest home and six from the hospital), identified that in all eleven files a nursing assessment was completed within 24 hours and eleven of eleven files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes. Eleven of eleven care plans reviewed evidenced evaluations completed at least six monthly.

Tracer Methodology rest home:

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

Tracer methodology hospital:

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

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

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

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. Nutrition and pain are assessed on admission and as needed and weights and BP's are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. All residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Eleven resident interviews (five from the rest home and six from the hospital), and five of five relatives (three from the hospital and two from the rest home), stated they were informed and involved in the assessment process.

**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.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents' files include; initial assessment, daily progress notes, Blood Pressure (BP) and weight recordings, short term care plans, long term care plans, risk assessments/nutrition, regular evaluations, GP initial assessment and visits, lab results, NASC assessment, allied health reports, activities, consents, advance directives, letters, referrals and archived notes.

Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. All eleven care plans reviewed (five from the rest home and six from the hospital) were evidenced to be up to date. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

Four of eleven care plans sampled do not reflect interventions for all current needs of the resident. This is an area requiring improvement.

Areas covered in the eleven resident files (five from the rest home and six from the hospital), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, ADL's, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families are well documented.

D16.3k; Short term care plans are in use for changes in health status.

D16.3f; Eleven resident files reviewed identified that family were involved.

### 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.

**Attainment and Risk:** PA Moderate

**Evidence:**

Areas covered in the eleven resident files (five from the rest home and six from the hospital), sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, Activities of Daily Living (ADL's), nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families are well documented.

<b>Finding:</b>
Four of eleven care plans sampled do not reflect interventions for all current needs of the resident.
<b>Corrective Action:</b>
Ensure all care plans reflect interventions for all current needs.
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Service delivery plans demonstrate service integration.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b>
The service provides services for residents requiring rest home, hospital level care. Care plans are completed comprehensively. Eleven residents files (five from the rest home and six from the hospital), were reviewed for this audit: Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Care plans evidenced at least six monthly care plan reviews. The use of short term care plans is evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with six health care assistants who work both am and pm shifts and who work across rest home and hospital levels of care. Five of five relatives (three from the hospital and two from the rest home) four registered nurses, one enrolled nurse, the clinical manager (RN) and the facility manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by their own GP.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

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, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for ten residents with wounds. Three residents have pressure areas. Nine of 21 wounds do not have a timeframe documented for the next review. Two of 21 wounds have not been reviewed within stated timeframes. These are areas requiring improvement.

On interview the four registered nurses and the clinical manager stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There is evidence in files of the wound specialist referrals.

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

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

**Attainment and Risk:** PA Moderate

#### **Evidence:**

The service provides services for residents requiring rest home, hospital level care. Care plans are completed comprehensively.

Eleven residents files (five from the rest home and six from the hospital), were reviewed for this audit: Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Care plans evidenced at least six monthly care plan reviews. The use of short term care plans is evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with six health care assistants who work both am and pm shifts and who work across rest home and hospital levels of care. Five of five relatives (three from the hospital and two from the rest home) four registered nurses, one enrolled nurse, the clinical manager (RN) and the facility manager. The GP interviewed stated the facility applied changes of care advice immediately and was highly complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by their own GP. There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

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, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for ten residents with wounds. Three residents have pressure areas.

#### **Finding:**

(i) Nine of 21 wounds do not have a timeframe for the next review documented. (ii) Two of 21 wounds have not been reviewed within stated timeframes.

#### **Corrective Action:**

(i) Ensure that all wound management plans have timeframes for review date. (ii) Ensure that all wounds are reviewed within stated timeframes

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three activities coordinators employed. One works 27 hours per week, one 37.5 hours and one 30 hours. They work over five days. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo movies and outings. There are also visits from community groups. Five of five relatives (three from the hospital and two from the rest home), interviewed stated that activities are appropriate and varied enough for the residents. Eleven of 11 residents (five from the rest home and six from the hospital), interviewed stated they were happy with the activities available and are given a choice regarding attendance.  
D16.5d: Eleven resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All initial care plans were developed by an registered nurse within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all eleven care plans reviewed. Overall changes in health status are documented and followed up. Care plan reviews are signed as completed by an registered nurse. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

D16.3c: All initial care plans were evaluated by the registered nurse within three weeks of admission.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The service facilitates access to other medical and non-medical services. Referral forms and documentation are maintained on resident files. There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. Follow up occurs as appropriate.</p> <p>D16.4c: The service provided an archived example of when a resident's condition had changed and the resident was reassessed for a higher level of care. Currently no residents are awaiting a NASC reassessment.</p> <p>D 20.1: Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, district nurses, podiatrist and physiotherapy services.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**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

**Attainment and Risk:** FA

**Evidence:**

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 22 medication charts sampled had allergies (or nil known), documented. Nine of 22 medication charts sampled have PRN medications charted with no frequency or maximum dose charted. Five of 22 medication charts sampled have regular medications charted that have not always been signed as administered. These are areas requiring improvement. There are drug trolleys that are kept in the nurses' stations which are locked when not in use. The service documents adverse reactions and errors on incident/accident forms. There is a locked cupboard that is used for controlled drugs. In hospital B and the rest home the weekly control drugs (CD) checks have not always occurred. This is also an area requiring improvement. Medication round observed; all practice is appropriate. A medication competency has been completed annually by all staff who administer medication. There is a policy and process that describes self-administered medicines. There is currently one resident who self-administers medication. The resident has a current annual competency check. D16. Twenty two medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident. Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs. The fridge that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication record. All 22 medication charts sampled had allergies (or nil known), documented.

**Finding:**

(i) Nine of 22 medication charts sampled have PRN medications charted with no frequency or maximum dose charted. (ii) Five of 22 medication charts sampled have regular medications charted that have not always been signed as administered. (iii) In hospital B and the rest home the weekly CD checks have not always occurred.

**Corrective Action:**

(i) Ensure all prn medication have frequency and maximum dosage charted medications are signed for. (ii) Ensure that all regular medication is administered and signed for. (iii) Ensure that the CDs are checked weekly.

**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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs ten staff to provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. A registered nurse completes each resident's nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen

Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.

The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.

The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.

Food audits are carried out as per the yearly audit schedule.

D19.2: Kitchen staff have been trained in safe food handling.

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

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

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

**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.

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

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency manual available to staff which includes hazardous substances. Six healthcare assistants, four registered nurses, one enrolled nurse, the clinical manager and the three activities coordinators and the facility manager interviewed were able to describe hazard management. There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical training occurs annually. All chemicals sighted were appropriately stored in locked areas. Chemicals are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.</p>

**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.

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

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building holds a current warrant of fitness which expires on 8 December 2014. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. The facility's amenities, fixtures, equipment and furniture are appropriate for rest home and hospital residents. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident's bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

### 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

**Attainment and Risk:** FA

**Evidence:**

All resident rooms have direct access to an ensuite with a toilet and hand basin. There are sufficient communal showers to meet the needs of all residents. Communal toilets have adequate signage. Visitor/staff toilets are well signed. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented.

#### 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.

**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 1.4.4: 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

**Attainment and Risk:** FA

**Evidence:**

There is adequate space in all bedrooms for residents and staff. Six health care assistants were asked if there was sufficient room and they confirmed they were able to

move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Eleven of 11 residents (five from the rest home and six from the hospital) are happy with their rooms.

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has a main lounge and separate dining area in each wing. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout facility in wheel chairs and walking frames. Residents are able to move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements and give wheelchair access. Activities occur in the main lounge and residents are able to access their rooms for privacy when required. Eleven of 11 residents (five from the rest home and six from the hospital) are happy with the communal areas.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are cleaning policies and processes . Cleaning audits occur. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**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 1.4.7: 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:**

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence box is available (sighted). The facility manager stated that they have spare blankets and alternative cooking methods if required (viewed). There is sufficient water stored in a tank to ensure for three litres per day for three days per resident.

The staffing level provided adequate numbers of staff to facilitate safe care to rest home and hospital level. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme in 2006. Fire drills have occurred six monthly, last on 17 October 2013.

There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> General living areas and resident rooms are appropriately heated and ventilated. The facility has under floor heating that is thermostatically controlled. All bedrooms and communal areas have at least one external window.

**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.

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

### 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.

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

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

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### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Restraint Minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance. Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.

There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed. The restraint group at Arran Court are the four restraint coordinators (all registered nurses), the facility manager, the clinical manager, and a general practitioner. The restraint coordinators complete a restraint orientation. Health care assistants and all registered nurses complete an annual restraint competency. Staff training on the management of challenging behaviours was held in October 2013 and on restraint in April 2013.

There are three residents with enablers in the form of bedsides. Bedsides are in use while the resident is in bed and one hourly monitoring is conducted while the bedsides are in position. These restraints were requested by the residents.

The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler.

There are 12 residents using restraint (all are bedsides).

#### **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.

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

## **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:** FA

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three monthly at Arran Court and as part of the care plan review and multidisciplinary review that involves family/whanau. This had occurred for each of the two files reviewed for residents using restraint.

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 2.2.2: 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:** FA

**Evidence:**

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. All assessments are reviewed by the clinical manager as sighted in the two files sampled for residents who use restraints.

Assessments are completed as required for individual residents. The three files sampled identify that a restraint assessment, discussion and alternatives form and restraint discussion and consent form were completed for the two residents requiring restraint and an enabler assessment and consent form is completed for the one residents requiring an enabler whose files were sampled.

#### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

At Arran Court the four restraint coordinators (all registered nurses), the facility manager, the clinical manager, and a general practitioner are the restraint group. The family/whanau is involved in the consent process and at times of review.

The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. There are approved restraints

documented in the policy. The approval process includes ensuring the environment is appropriate and safe. The restraint assessment identifies specific interventions or strategies to try (as appropriate) before using restraint.

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and its outcome that aligns with a) - g) in this criterion. Restraint monitoring forms include type of restraint used, risks associated with type of restraint, times restraint on/off, toileting, wheelchair lap belt use and repositioning of a resident when in bed. Forms include assessment, monitoring, risks, consent and alternatives to restraint. Three files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. Monitoring forms were completed. A monthly evaluation of restraint and enablers was completed. The service has a restraint register and an enablers register that records sufficient information to provide an auditable record of restraint use.

#### **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.

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

#### **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.

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

**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.

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

## 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:** FA

**Evidence:**

The files reviewed of residents requiring restraint are evaluated three monthly. Family/whanau participates in evaluations and also at the residents' multidisciplinary review. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). Restraint practices are reviewed on a formal basis in the staff meetings and quality meetings. A restraint evaluation is completed of the restraint care plan three monthly. Evaluation timeframes are determined by risk levels. Family/whanau is involved in review at residents' annual multidisciplinary review.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  Approved restraint for each individual is reviewed at least three monthly by the restraint approval group and as part of the annual multidisciplinary review with family/whanau involvement.  Restraint usage across the facility is monitored monthly and is discussed at monthly staff and CQI meetings. The clinical manager meets monthly with the restraint coordinators and the restraint group meets annually to review the restraint programme. Restraint usage is also benchmarked across the organisation and is reviewed at the organisational level.

### 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.

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

## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is an Infection control (IC) programme for 2013 that includes documented goals, success factors, education, surveillance and antimicrobial usage. The programmes content and detail is appropriate for the size and complexity of the services. There are IC policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. IC is part of the Radius benchmarking programme.</p> <p>The IC programme is reviewed annually for the Radius group with the content and detail being designed to be appropriate for the size and complexity of the organisation. The facility manager and IC coordinator are responsible for the development of site specific IC goals.</p> <p>The IC coordinator could describe how an outbreak would be managed and reported. There was a norovirus outbreak in January 2013 and documentation shows this was well managed. There are guidelines and staff health policies for staff to prevent the spread of infection. These include, but not limited to; outbreak management policy and flow chart, pandemic plan and policy, food handlers sickness policy and hand hygiene policy.</p>

**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.

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

**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.

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

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The IC coordinator (a registered nurse) collates monitoring data and reports through to the monthly quality meetings. Outcomes are reported to staff through nursing and staff meetings. The IC coordinator receives on-going education and attended a Bug Control training day in July 2013. In the event of the IC coordinator requiring advice this is available through the GP, Pathlab or Bug Control.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### 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:**

D 19.2a: The Infection Control Manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. Policies include; antimicrobial guidelines, decontamination, food handlers sickness policy, hand hygiene, management of staff with communicable diseases, MRO, outbreak management, pandemic plan, respiratory hygiene, scabies management, single use items, transmission based precautions, UTIs, waste management, . Associated policies include. Wound management policy, continence policy, laundry and kitchen policies. There is comprehensive Infection Control policies that support the Infection Control Standard SNZ HB 8134:2008. The infection control policies link to other documentation and uses references where appropriate.

Infection control policies are reviewed as part of the policy review process by Radius input is sought form facilities when reviewing policies.

#### 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.

**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

**Attainment and Risk:** FA

**Evidence:**

The IC coordinator undertook Bug Control training in July 2013. The IC coordinator ensures training is provided to staff. Informal education is also provided - availability of education was confirmed by six healthcare assistants interviewed.

The orientation package includes specific training around hand washing and standard precautions. Training on infection control was last provided in October 2013. Hand washing is an annual competency.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.

#### 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.

**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.

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme - IC surveillance audit was last undertaken October 2013 (100% compliance). The service submits data monthly to Radius head office where benchmarking is completed. There were no corrective action requirements from the audit programme.</p> <p>The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the quality meetings and also to staff meetings. Monthly data was seen in staff areas.</p>

#### 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.

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

**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.

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