# Springlands Senior Living Limited

## Current Status: 27 November 2013

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

## General overview

Springlands Retirement Village provides rest home and hospital level care for up to 56 residents. There are also 20 serviced apartments approved to provide rest home level care. On the day of the audit there were 51 residents; 31 rest home residents including one resident in the serviced apartments and 20 hospital residents.

The village manager has been in the position for three years. She has a New Zealand Diploma in Management.

A nurse manager is employed to oversee the running of the rest home and hospital. The nurse manager has been in the role for seven months and has previous management experience. She is completing a master’s degree in nursing and is a Careerforce assessor. The nurse manager is supported by the charge nurse for the hospital wing and registered nurses.

Springlands introduced a new quality and risk management system with associated policies in February 2013. There is a business plan and risk management plan. The business plan has documented staff input with staff discussion regarding the business plan in staff meetings.

Staff interviewed and documentation reviewed identified that the service is proactively implementing the new quality and risk systems. Family and residents interviewed all spoke positively about the care and support provided. This audit identified an improvement required relating to aspects of care plan documentation and hot water temperature monitoring.

## Audit Summary as at 27 November 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 27 November 2013

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

### Organisational Management as at 27 November 2013

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 27 November 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 low risk. |

### Safe and Appropriate Environment as at 27 November 2013

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 27 November 2013

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 27 November 2013

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

## Audit Results as at 27 November 2013

### Consumer Rights

Springlands provides a safe and culturally appropriate service for the residents. Residents and relatives spoke positively about care provided at the facility. There is a Maori Health Plan and implemented policy supporting practice. Policies are implemented to support resident’s rights. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Springlands introduced a new quality and risk management system with associated policies in February 2013. The system supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. A review of the documentation evidences a proactive approach around implementation of this quality system.

An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. The facility staffing policy aligns with contractual requirements and includes skill mixes.

### Continuum of Service Delivery

The service has admission policies and procedures. Needs assessment approval is required prior to entry for rest home and hospital level of care. Service information is made available on enquiry and additional information is available on admission. Residents/relatives confirmed the admission process and the admission agreement were discussed with them. Registered nurses (RN's) are responsible for each stage of service provision. There is evidence of resident/family participation in the development of the care plans. Long-term care plans are reviewed three monthly for hospital residents and at least six monthly for rest home residents. There are three monthly multidisciplinary reviews. Risk assessments tools are available. Care plans demonstrate service integration and guide all staff in cares. There is an improvement required around interventions to support management of altered behaviours and include risks identified with the use of restraint. .

There are policies and procedures for medicine management. Registered nurses are responsible for the administration of medicines and complete annual medication competencies and education. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The GP reviews the medication records three monthly.

The activities programme is facilitated by an activities co-ordinator. Each resident has an individualised activity plan, which is reviewed at the same time as the clinical care plan. The activities programme provides varied options and activities that meet the consumer group. Links with the community are maintained and van outings are arranged on a regular basis.

All food is cooked on site. Residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. The cooks are qualified and staff have undertaken food safety and hygiene training.

### Safe and Appropriate Environment

There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are stored safely on delivery to the facility. There is an improvement required around the storage of chemicals in the cleaning and kitchen areas. There is correct labelling of chemical bottles. Appropriate protective equipment and clothing is available for staff. The interior of the home is spacious, light and clean. The building holds a current warrant of fitness. Residents interviewed state the facility is warm and comfortable. Planned internal and external maintenance schedules are in place. Equipment is serviced annually. There is an improvement required regarding the monitoring of hot water temperatures. The external gardens and grounds are well maintained, accessible and safe for residents and family members.

Training, information, and equipment for responding to emergencies are provided. Fire training is completed at orientation and fire evacuations are held six monthly.

### Restraint Minimisation and Safe Practice

The service has comprehensive restraint minimisation policies. The service currently has nine hospital residents assessed as requiring the use of restraint and two with enablers. There is one enabler in the rest home in the form of a bedrail. The care plans are up to date and include reference to the restraint/ enabler in use. Challenging behaviour assessments are completed as required.

Restraint meetings and audits are undertaken three times a year and are documented.

Staff received training around restraint minimisation and the management of challenging behaviour/ de-escalation has been provided. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.

### Infection Prevention and Control

The infection control (IC) team is led by the clinical nurse manager with a registered nurse for each of the rest home and hospital wings acting as ‘link nurses’ for the areas. The infection control policy identifies clearly the roles of the IC nurse and supporting team.

The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through two monthly staff meetings. Staff are informed about IC practises and reporting through staff meetings, training and information posted up on staff notice boards. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC nurse and entered into the infection register.

The service has developed strong links with the public health service with a member of this service providing training to staff and advice as needed.

There is a job description for the IC nurse including the role and responsibilities of the infection control coordinator. There are policies and an infection control manual to guide staff to prevent the spread of infection.

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Springlands Senior Living Limited |
| **Certificate name:** | Springlands Lifestyle Village |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | Springlands Lifestyle Village, 5 Battys Road Blenheim | | | |
| **Services audited:** | Medical, Geriatric, Rest home care | | | |
| **Dates of audit:** | **Start date:** | 27 November 2013 | **End date:** | 28 November 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 51 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 18 | Total audit hours | 42 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 52 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Friday, 10 January 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Springlands Retirement Village provides rest home and hospital level care for up to 56 residents. There are also 20 serviced apartments approved to provide rest home level care. On the day of the audit there were 51 residents; 31 rest home including one resident in the serviced apartments and 20 hospital residents.  The village manager has been in the position for three years. She has a New Zealand Diploma in Management.  A nurse manager is employed to oversee the running of the rest home and hospital. The nurse manager has been in the role for seven months and has previous management experience. She is completing a master’s degree in nursing and is a Careerforce assessor. The nurse manager is supported by the charge nurse for the hospital wing and registered nurses.  Springlands introduced a new quality and risk management systems with associated policies February 2013. There is a business plan and risk management plan. The business plan has documented staff input with staff discussion regarding the business plan in staff meetings.  Staff interviewed and documentation reviewed identified that the service is proactively implementing the new quality and risk systems. Family and residents interviewed all spoke positively about the care and support provided. This audit identified an improvement required relating to aspects of care plan documentation and hot water temperature monitoring. |

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| **Outcome 1.1: Consumer Rights** |
| Springlands provides a safe and culturally appropriate service for the residents. Residents and relatives spoke positively about care provided at the facility. There is a Maori Health Plan and implemented policy supporting practice. Policies are implemented to support resident’s rights. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community. |

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| **Outcome 1.2: Organisational Management** |
| Springlands introduced a new quality and risk management systems with associated policies February 2013. The system supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality meetings. A review of the documentation evidences a proactive approach around implementation of this quality system.  An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings.  There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. The facility staffing policy aligns with contractual requirements and includes skill mixes. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has admission policies and procedures. Needs assessment approval is required prior to entry for rest home and hospital level of care. Service information is made available on enquiry and additional information is available on admission. Residents/relatives confirmed the admission process and the admission agreement were discussed with them. Registered nurses (RN's) are responsible for each stage of service provision. There is evidence of resident/family participation in the development of the care plans. Long-term care plans are reviewed three monthly for hospital residents and at least six monthly for rest home residents. There are three monthly multidisciplinary reviews. Risk assessments tools are available. Care plans demonstrate service integration and guide all staff in cares. There is an improvement required around interventions to support management of altered behaviours and include risks identified with the use of restraint. .  There are policies and procedures for medicine management. Registered nurses are responsible for the administration of medicines and complete annual medication competencies and education. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The GP reviews the medication records three monthly.  The activities programme is facilitated by an activities co-ordinator. Each resident has an individualised activity plan, which is reviewed at the same time as the clinical care plan. The activities programme provides varied options and activities that meet the consumer group. Links with the community are maintained and van outings are arranged on a regular basis.  All food is cooked on site. Residents' nutritional needs are identified and accommodated with alternative choices provided. Meals are well presented, homely and the menu plans have been reviewed by a dietitian. The cooks are qualified and staff have undertaken food safety and hygiene training. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are stored safely on delivery to the facility. There is an improvement required around the storage of chemicals in the cleaning and kitchen areas. There is correct labelling of chemical bottles. Appropriate protective equipment and clothing is available for staff. The interior of the home is spacious, light and clean. The building holds a current warrant of fitness. Residents interviewed state the facility is warm and comfortable. Planned internal and external maintenance schedules are in place. Equipment is serviced annually. There is an improvement required regarding the monitoring of hot water temperatures. The external gardens and grounds are well maintained, accessible and safe for residents and family members. Training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has comprehensive restraint minimisation policies. The service currently has nine hospital residents assessed as requiring the use of restraint and two with enablers. There is one enabler in the rest home in the form of a bedrail. The care plans are up to date and include reference to the restraint/ enabler in use. Challenging behaviour assessments are completed as required. Restraint meetings and audits are undertaken three times a year and are documented. Staff received training around restraint minimisation and the management of challenging behaviour/ de-escalation has been provided. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control (IC) team is led by the clinical nurse manager with a registered nurse for each of the rest home and hospital wings acting as ‘link nurses’ for the areas. The infection control policy identifies clearly the roles of the IC nurse and supporting team. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through two monthly staff meetings. Staff are informed about IC practises and reporting through staff meetings, training and information posted up on staff notice boards. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC nurse and entered into the infection register. The service has developed strong links with the public health service with a member of this service providing training to staff and advice as needed. There is a job description for the IC nurse including the role and responsibilities of the infection control coordinator. There are policies and an infection control manual to guide staff to prevent the spread of infection. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 98 | 0 | 2 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | i) The long-term care plan of one hospital resident states the resident does not have any challenging behaviours. The resident has altered moods and has been seen by the OPMH. ii) The outcomes of a behavioural assessment for a second hospital resident is not reflected in the long-term care plan. iii) One of four hospital resident files sampled has restraint use in place. There are no risks identified for restraint use documented in the long term care plan | i)and ii) Ensure care plans reflect behaviour changes, management and alternative strategies for residents with altered behaviours.  iii) Ensure care plans identify risks associated with restraint use. | 90 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | There is no evidence of monthly hot water temperature monitoring. | Ensure hot water temperature monitoring is conducted monthly as per the monthly maintenance schedule. | 30 |

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a range of policies and procedures to ensure that resident’s rights are protected. This includes a code of rights policy, confidentiality and privacy policy and abuse and neglect policy.  Staff signs confidentiality agreements on employment and ‘house rules’ during orientation. On interview all health care assistants, and registered nurses interviewed were aware of consumer’s rights and were able to describe how they incorporated consumer rights within their service delivery.  Code of Rights is included in the annual training schedule (last training August 2013, 11 staff attended).  Eight residents (two rest homes and six hospital) and six family members interviewed spoke highly of respect for all aspects of the Code of Rights. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are posters of the Code of Rights on display in the foyer of the facility, leaflets from the Health and Disability Service and Advocacy service are also available in the foyer of the facility.  On entry to the service, residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview, all staff (six healthcare assistants, two registered nurses, and one clinical nurse manager) stated that they take time to explain the rights to residents and their family members.  Eight residents and six family members confirmed that they had received information about their rights on entry to the service. The resident survey (July 2013) evidenced that some family members were unsure of who to talk to in the event of any questions. The service has subsequently sent a letter to all resident families. The letter gives information regarding the management structure and whom the families can discuss any problems with. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the nurse manager or registered nurse, discuss the information pack with the resident and the family/whānau. This includes the Code of Rights, complaints and advocacy.  D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a confidentiality and dignity policy and an intimacy and sexuality in the elderly policy.  All staff sign ‘house rules’ on employment which includes respect for residents and the service vision includes respect and independence. Staff were observed respecting resident’s privacy; knocking on doors and referring to residents by their preferred names for example.  All eight residents and six family members interviewed indicated staff were highly respectful and maintained resident’s privacy.  Resident preferences are identified during the admission and care-planning processes occur with family involvement. On interview, all confirmed they are consulted by staff about their care. There is a preventing abuse and neglect policy and the topic is covered at orientation. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues.  Code of Rights training by the local health advocate included abuse and neglect training and last occurred in August 2013,11 staff attended.  D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. D4.1a Resident files reviewed identified that cultural, spiritual values and individual preferences are documented. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has established cultural policies to help meet the cultural needs of the residents. There is a Maori health plan in place. The rights of the resident to practise their own beliefs are acknowledged in the Maori health policy and plan. The Maori health plan includes aspects of cultural and spiritual care of other beliefs as well. Policies for Maori emphasise the critical importance of whānau. Discussions with the clinical nurse manager, registered nurses and healthcare assistants confirm that they are aware of the need to respond to cultural differences. On interview, all staff were able to identify how to obtain support so that they could respond appropriately. Cultural safety training last provided June 2013 with 17 staff attending. The service has one resident in the rest home that identifies as Maori. This resident’s care plan was reviewed specifically for cultural aspects of care. The plan documents the resident’s Iwi, and the involvement of whanau on a regular basis.  The service is able to access Maori advisors and local Iwi advocacy services through the DHB.  A3.2: There is a Maori health plan that includes a description of how the facility 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.

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a Maori health plan and policy, which includes culturally appropriate care for residents of other cultures. All eight residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural beliefs are included in the care plan.  D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has an abuse and neglect which states that will not be tolerated under any circumstances  Elderly abuse prevention training occurs at orientation and on a two yearly basis. The RN's supervise staff to ensure professional practice is maintained in the service.  Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |

##### **Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)**

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Since the previous certification audit, the service has introduced a new set of policies and procedures as well as a quality system purchased from an external contractor. The new policies are comprehensive; they guide practice that aligns with the Health and Disability Services Standards. The service was able to evidence its process of ensuring all staff read the new policies with signing sheets. The process is well advanced at the facility. There is a quality and risk framework and programme that is being implemented that includes performance monitoring. This new quality framework was introduced February 2013 and the implementation of the system has been integrated consistently since then. The clinical nurse manager and village manager have been instrumental in signing a memo of understanding with Canterbury DHB for registered nurses PDRP with all registered nurses now enrolled.  Career force for healthcare assistants is well implemented with five staff attained level three, one commencing level two, one commencing level three and two commencing level four. Other staff include two healthcare assistants who are enrolled nurses who have chosen not to renew practicing certificates, and three student’s nurses.  A comprehensive internal in-service training programme has been commenced. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission, all residents are provided with an information pack which gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau. The pack includes a copy of the Health and Disability Code of Rights. This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide on-going feedback. There is an open disclosure policy which describes ways information can be provided to residents and families.  Regular contact is maintained with family including if an incident or care/ health issues arises. This was evidenced in 14 incident forms reviewed from both the rest home and hospital wings. Family members interviewed stated they were well informed and involved when needed in residents care. All eight resident files reviewed included signed admission agreements. There are regular residents meetings where any issues or concerns to residents are able to be discussed. The clinical nurse manager contacts family members by phone and / or emails monthly. There are informative newsletters to residents and families six monthly.  Annual resident and relative surveys are also completed. The most recent survey documents that families were confused following recent senior staff changes. The service has followed this up with a letter to families informing them of the management team and structure. The survey also showed that some resident were unhappy with, meal choices. The service has been proactive with the cook asking for meals suggestions in the most recent resident and family newsletter. The service has policies and procedures available to enable access to DHB interpreter services and residents (and family/whānau), are provided with this information in resident information packs. 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: family members stated that they are always informed when their family members health status changes. 'D11.3 The information pack is available in large print and advised that this can be read to residents. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Springlands has policies in place for advanced care planning, informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written consent is obtained general consent such as obtaining and sharing of medical information, photograph and outings, family involvement in care plan reviews, notification of changes in health and injuries. Six HCAs interviewed are able to describe situations where verbal consent is obtained. Copies of the residents enduring power of attorney (where available) is held on the residents file. Where a resident has been deemed incompetent the EPOA is actively involved in the residents care.  Review of eight resident files, four hospital and four rest home, all included appropriately signed resuscitation forms, general consent forms and evidence that advance directives are actively discussed with residents and family. Discussions with the clinical nurse manager identified that staff are familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.  D13.1 there were eight admission agreements sighted and eight had been signed on the day of admission D3.1.d Discussion with family members identified that the service actively involves them in decisions that affect their relatives lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an advocacy policy. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with health care assistants, residents and family members confirmed that they are aware of advocacy and how to access an advocate.  Code of rights training including advocacy was provided by the local health advocate August 2013 (11 staff attended). There are documented and well-developed links with age concern. D4.1d; Discussion with eight family identified that the service provides opportunities for the family/EPOA to be involved in decisions.  D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and family members confirmed this. D3.1h: Discussion with family members stated that they are encouraged to be involved with the service and care D3.1.e: Discussion with staff, residents and family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church, and community networks. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission.  There is a complaints register. The 2013 complaints were reviewed. Verbal and written complaints are documented. The complaints have noted acknowledgement, investigation, timelines, corrective actions when required and resolutions. Results are feedback to complainants.  There are a series of complaints from two particular families; the service has involved Age Concern with addressing and resolving the various issues involving the family, the resident and interactions with other residents. From a review of the issues raised it is clear the service is keen to ensure that the family and the residents rights are respected, whist addressing the various concerns from and about the family. Discussions with eight residents and six family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with health care assistants and registered nurses stated that concerns/complaints were discussed at two monthly staff meetings and this was verified on meeting minutes reviewed. Complaints are also an agenda item for the weekly management meeting. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Springlands Retirement Village provides rest home and hospital level care for up to 56 residents (all swing beds). There are also up to 20 serviced apartments approved as being able to provide rest home care. On the day of the audit there were 51 residents; 31 rest home including one resident in the serviced apartments and 20 hospital residents. There is a retirement village attached as part of the complex with overall management of the site provided by the village manager.  The village manager has been in the position for three years. She has a New Zealand Diploma in Management.  A clinical nurse manager is employed to oversee the running of the rest home and hospital. The nurse manager has been in the role for seven months and has previous management experience; she is completing a master’s degree in nursing and is a Career force assessor. Springlands introduced a new quality and risk management systems with associated policies February 2013. There is a business plan and risk management plan. The Business plan has documented staff input with staff discussion regarding the business plan in staff meetings (documented October 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 rest home and hospital. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During a temporary absence, the clinical nurse manager covers the village manager’s role. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D5.4 :The service has introduced new policies from an external contractor. There is a process of releasing policies for all care staff to read and sign once read. This process is well implemented. Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a secure area.  The new quality system, introduced February 2013, has been fully embraced by the service as documented by meeting minutes reviewed and discussion with staff. The system includes a comprehensive audit schedule. The village manager and clinical nurse manager manage quality system jointly. There are regular meetings that include; two monthly staff meetings, weekly management/ quality meetings, six weekly health and safety meetings, monthly infection control meetings and monthly clinical meetings.  The management and clinical meetings have standing agenda items on the programme that include audit, infection, incidents, complaints and health and safety. Information is then reported back to the staff meeting. The village manager reports monthly to the managing director who also receives the minutes of the weekly management meeting. Audits are undertaken according to the audit schedule and reported back to meetings. Three months audits and follow up were specifically reviewed. All audits were documented as undertaken according to the monthly plan. All audits had an action plan where needed and all documented follow-up at staff and management meetings. Audit outcomes are emailed to all RNs individually and signed off by the clinical nurse manager. There is evidence that audit outcomes are used to improve services. An example includes the food service audit April 2013. The outcome resulted in a dietitian review of the meals and a ‘no hat- no serves’ policy implemented in the kitchen. Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. The clinical nurse manager analyses all infection control statistics and restraint and enabler usage is documented.  Monthly benchmarking occurs and all monthly results are graphed and posted up on the nurse’s station notice board. The graphs are also presented at two monthly staff meetings and are part of the monthly report to the managing director. D19.3 there is implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g Falls prevention strategies such as physiotherapy reviews. There is a comprehensive health and safety and risk management programme in place. There is a designated as Health and Safety officer. Staff interviewed (six HCAs, two registered nurses and the clinical nurse manager) are knowledgeable about health and safety. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is up to date and reviewed at six weekly health and safety meetings. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b: Springlands has an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  The service collects a wide range of data relating to incidents and accidents. The reporting system is integrated into the quality risk management system. All incident and accident forms are scanned with originals retained the resident file. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the nurse manager or RN who monitor issues. If risks are identified these are also processed as hazards.  Data relating to incidents are inputted into the computer by the clinical nurse monthly on a monthly basis. The information is reviewed, collated and graphs produced. These graphs are posted up on the notice board in the nurse station(s). The information is also reported to the two monthly staff meetings and also in the monthly report to the managing director. Fourteen incident forms were viewed from September. Two residents in the hospital were responsible for six of the falls (three falls each) One of the residents sustained two skin tears and one resident sustained one skin tear. Both resident files documented that the skin tears had been followed up with wound care plans. Long-term care plans also documented that skin care was documented well to protect vulnerable skin. One resident in the rest home also sustained four falls. This resident care plan includes a pendant call bell following the fall(s) as the resident often falls away from calls bells (corridors and outside for instance). All incident forms documented follow up by the RN and family informed.. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Eight staff files were reviewed for this audit. Four health care assistants, two registered nurses, one clinical nurse manager and one DT.  All eight files documented a relevant job description and employment contacts. Four new staff (three health care assistants and one registered nurse) all had a documented orientation. The RN who had been employed over a year had an appraisal using the DHB scope of practice process and document. Annual appraisals were also in place for the remainder three staff. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioner’s certification including GP; pharmacist there is a training/induction process that describes the management of orientation. Interview with six health care assistants described the orientation programme that includes a period of supervision. They also reported that supervision can be extended if needed. This was verified by the clinical nurse manager and village manager.  The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Each session includes an attendance sheet, training content.  Comprehensive records are kept. Interview with staff inform there is access to sufficient training.  Medication competencies are completed for all nurses and health care assistants who administer medication  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint, syringe driver and insulin administration. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. All staff reported that staffing levels and the skill mix was appropriate and safe.  All eight resident interviewed felt there was sufficient staffing. The service has a staffing levels policy implemented which determines that there are registered nurses on duty at all times, and that at least one staff member on duty will hold a current first aid qualification.  Registered nurses are rostered on 24 hours per day. There is a Nurse manager who overlooks the hospital and rest home. There is a registered nurse rostered for the rest home. Health Care assistants are rostered by rest home and hospital with a separate healthcare assistant rostered for the serviced apartments. The nurse manager provides cover for the village manager during her absences and holidays and the charge nurse for the nurse 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).  All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long-term care plans, and any medical reports such as radiology and pathology.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured room. Old files are individually archived and locked in a secure area for 10 years. Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible, signed and dated by the RN's and healthcare assistants. Medical notes and allied health input are signed and dated appropriately.  D7.1: Entries are legible, dates and signed by the relevant caregiver or nurse including designation. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry, potential residents have a needs assessment, completed by the needs assessment and co-ordination service, support works. Admissions are mostly received through the assessment, treatment and rehabilitation unit at Marlborough DHB. Levels of care are confirmed and arrangements made for admission. The nurse manager (NM) meets with Hospice prior to admission of palliative care residents and also meets with the resident and family. The NM screens all potential enquiries.  The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. D13.3 The admission agreements reviewed in eight resident files (four hospital and four rest home) align with a) -k) of the ARC contract.  D14.1 exclusions from the service are included in the admission agreement. D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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

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

ARHSS D4.2

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.2, 3, 4: The eight files reviewed (4 rest home [one in serviced apartment, one young person with a disability (YPD), two rest home] and four hospital files) identified that in all eight files an assessment was completed within 24 hours and all eight files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Seven care plans evidenced evaluations completed at least six monthly. One resident has not been in the service six months.   A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); Robinsons resident acuity assessment, health status and clinical risk assessment, coombes falls risk assessment, Braden pressure area assessment, food and nutritional assessment, continence assessment, pain assessment, challenging behaviour assessment.  There is a verbal handover for all oncoming shifts and a written handover sheet detailing any resident significant care, care plan reviews or medical events. Staff are required sign the handover sheet to confirm they have read the form. There is also a registered nurse handover in the hospital wing. In the rest home, the night shift handover to the oncoming shift and the registered nurse receives an update/handover at 8am. There is an RN diary with entries regarding appointment, medical tests, supplies required.    D16.5e: Eight resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. There are seven GP's from different practices who provide medical services to their patients at the facility. The RN interviewed stated the residents retain their own GP. The GPs conduct three monthly review visits and are notified by fax with any resident concerns. The GP interviewed visits three monthly for routine medical reviews and is available for visits at any other time. The GP is notified of any resident concerns in a timely manner. Ambulant residents attend the surgery where practical. The GP has confidence in the clinical assessments and transfers to hospital (nurse initiated) are appropriate. The GP states her patients receive good care and the staff are polite, respectful and professional. There is an afterhours GP service until 10pm. Any urgent medical concerns are then referred to the local emergency department. There is evidence of allied health professional involvement in the provision of service such as wound care nurse, district nurse, palliative care/hospice, physiotherapist, dietitian, speech language therapist, continence nurse and podiatrist.  Tracer methodology; Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology; Hospital resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, and long-term care plan within the required timeframes.  All resident files sampled (four rest home and four hospital) evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives interviewed and residents (six hospital, two rest home) advised on interview that assessments were completed in the privacy of their room. A range of assessment tools are completed in resident files on admission and reviewed three monthly for hospital residents and six monthly for rest home residents included (but not limited to); Robinsons resident acuity assessment, health status and clinical risk assessment, Coombes falls risk assessment, braden pressure area assessment, food and nutritional assessment, continence assessment, pain assessment, challenging behaviour assessment. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial nursing assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse develops the long-term care plan from information gathered over the first three weeks of admission. The long term care plan includes safety/potential for injury/risk assessment, mobility, continence/elimination, activities of daily living, dietary needs, medication, sleep/comfort/sexuality and intimacy, pain management, communication/sensory, memory loss/confusion, behaviour management, respiratory function, spiritual/cultural/social, skin/wound care.  Advance care planning needs and specific requests are additional documents added to the care plan. The clinical manager is liaising with the hospice educator to develop an advanced care plan and end of life education for RNs and health care assistants. The integrated resident file also contains the admission documentation, informed consent forms and advance directives, EPOA, care documents, risk assessment tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance and other interventions), infection events summary, referral letters and correspondence, needs assessment approval and admission agreements.   D16.3k, Short-term care plans are available for use to document any changes in health needs. Short-term care plans were evidenced for shingles, weight loss, and bronchitis. Short-term care plans are evaluated at regular intervals and either resolved or added to the long-term care plan if an on-going problem.  Medical GP notes and allied health professional progress notes are evident in the eight residents integrated files sampled. Relatives interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events and changes in health status. Family contact forms sighted in the resident individual record evidenced family are informed of any health changes, incidents/accidents, infections, specialist visits, care plan review, weight loss. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Family members and residents (six hospital and two rest home) interviewed reported the residents needs were being appropriately met. Care plans identify the resident’s problems/needs, objectives and interventions to assist the resident in achieving their goals.  The clinical manager, charge nurse and one registered nurse interviewed described the referral process should they require assistance from a wound specialist or continence nurse. 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 one wound, removal of lesion, two XXXX, six skin tears, and one pressure area sacrum in the rest home and 12 skin tears, four leg ulcers, one XXXX, pressure area of toes and pressure area of heel in the hospital wing. The wound assessment form has been recently reviewed to include medical condition and contributing factors that may delay healing. Photographs are taken of chronic wounds There is evidence of a referral to wound care specialist for a chronic wound. There are adequate pressure area resources such as pressure area mattresses, roho cushions and heel protectors. If necessary additional pressure area resources can be hired.    Food and nutritional assessments are completed on admission and reviewed at least six monthly or earlier if required. Residents are weighed monthly on chair scales (calibrated April 14). A short-term care plan and nutritional assessment is completed for any resident with unintentional weight loss. Interventions sighted include; weekly weigh, re-assessment of food dislikes and likes, high calorie diet, dietary supplement (such as complan) A dietitian referral is initiated if there is no weight gain. Special authority is obtained for diasip, ensure as appropriate. Complan is provided as required. It is recommended that an administration record be kept of all supplementary fluids (non-prescribed and prescribed). The GP is informed as evidenced in the medical notes of one resident record sampled with weight loss.   A Coombes falls risk identifies the resident level of falls risk. Interventions are then documented on the care plan. All falls are reported on the accident/incident form and to the RN on duty. Corrective actions are implemented as evidenced such as ultra-low beds, sensor mats, the wearing of good fitting footwear, ensuring rooms are not cluttered and review of medications.  Challenging behaviours are monitored on behaviour monitoring charts. Challenging behaviour assessments are completed. The GP is notified and medical cause excluded or identified as possible trigger for challenging behaviours. The GP initiates any referrals to Older Persons Mental Health service. There is evidence of psychiatric reviews and follow up visits for two hospital level residents with altered behaviour. There is an improvement required around documenting altered behaviours and interventions in the care plan and risks associated with restraint use. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Challenging behaviours are monitored on behaviour monitoring charts. Challenging behaviour assessments are completed. The GP is notified and medical cause excluded or identified as possible trigger for challenging behaviours. The GP initiates any referrals to Older Persons Mental Health (OPMH) service. There is evidence of psychiatric reviews and follow up visits for two hospital level residents with altered behaviour.  Residents are assessed by the restraint co-ordinator prior to the use of restraints. Restraint is documented on the long-term care plan. |
| **Finding:** |
| i) The long-term care plan of one hospital resident states the resident does not have any challenging behaviours. The resident has altered moods and has been seen by the OPMH. ii) The outcomes of a behavioural assessment for a second hospital resident is not reflected in the long-term care plan. iii) One of four hospital resident files sampled has restraint use in place. There are no risks identified for restraint use documented in the long term care plan |
| **Corrective Action:** |
| i)and ii) Ensure care plans reflect behaviour changes, management and alternative strategies for residents with altered behaviours.  iii) Ensure care plans identify risks associated with restraint use. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A qualified Diversional Therapist (DT) coordinates the activities programme for the hospital and rest home. The DT is a member of the N.Z. DT Society and attends the Blenheim DT forums and inter-rest home meetings for the sharing of ideas, suggestions and other networking. The DT is employed fulltime Monday to Friday. A part-time DT works two days a week (Tuesday and Thursday) and is available for reliever DT hours. She also volunteers at the Alzheimer’s society. The programme has been reviewed and now includes a separate programme for Wisteria (hospital wing) for the days there are two DTs. The additional hours allow for more one on one activities and another choice of activity for hospital residents. A volunteer assists on Fridays with activities such as discussions, reading and manicures. Weekend activities are arranged such as keyboard playing, entertainers and fortnightly Baptist church visitors. The weekly programme is bright colourful, in large print and delivered to the bedrooms and displayed on notice boards. A variety of group activities are offered including; newspaper reading, discussion and reading of interesting articles, exercises, walking group, housie, crafts, bowls, yoga, movies, charades, card group and happy hour. Activities provided in the hospital wing include one on one and balloon therapy, reading, massage, games, newspaper reading and wheelchair walks.  Guest speakers have been audiology during “loud shirt day”, SPCA and Age Concern. There is a Red Cross visiting service to residents. Residents are supported to maintain links in the community with one resident attending their church and Maori residents attend Kaumatua meetings weekly. Residents attend Senior citizen dances and RSA lunches. There is an interdenominational visiting chaplain service weekly, Catholic services held fortnightly and Care well church group meetings on-site. There are outings scheduled in the rest home van and a wheelchair taxi is hired for those residents who require wheelchair transport. Picnics have been enjoyed and outings are scheduled. Events such as International day of the older person and Chatham Island day have been celebrated. Both DTs have a first aid certificate.  The DT facilitates the resident monthly meetings where the activity programme is discussed and feedback sought as well as suggestions and ideas for the programme. On admission of a new resident the DT involves the resident and family to complete a resident profile. The care plan is completed within three weeks and there is a team approach to the development of the care plan and six monthly review occurs at the same time as the clinical care plan review. All DT care plans have been reviewed 2013. An attendance form is maintained that indicates invitations to activities, attendance or declined. There is evidence of communication with the family. Residents and families interviewed commented positively on the variety of activities offered. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are three monthly written resident reviews for hospital residents and six monthly reviews for rest home residents. There is a multidisciplinary approach to the reviews including the resident, family/whanau as appropriate, Nurse Manager, RN, Diversional therapist and GP. There is evidence of resident/family/whanau involvement in the review of care plans. Short-term care plans are evaluated with nursing problems resolved or if an on-going problem, transferred to the long-term care plan. GPs complete a medication review three monthly.  D16.4a A review of four of four rest home files identified that all four long term care plans have been evaluated six monthly or more frequently. A review of three of four hospital files identified that three long term care plans have been evaluated three monthly or more frequently. One resident has not been at the service long enough for an evaluation to take place.  D16.3c: All initial care plans of eight files sampled were evaluated by the RN within three weeks of admission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; district nurses, dietitian, geriatrician, dental, older persons mental health service, podiatry, physiotherapy, wound care specialist, eye specialist. There is evidence of GP discussion with families regarding referrals for treatment and options of care.  D 20.1 discussions with clinical manager, charge nurse and one registered nurse identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian and other allied health professionals. The GP initiates referrals to specialists and consultants. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical manager described the transfer documentation required is; Springlands transfer form, advance directive, medication chart, progress notes, and GP notes. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in residents record transferred from the DHB to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All medications are stored safely in the rest home and hospital wing medication room. The supplying pharmacy delivers the medication blister packs which are checked in by the RN on duty. A medication reconciliation record is kept of all checked blister packs and medication checks for new admissions and transfers into the facility. Any discrepancies are fed back to the pharmacy or prescriber. PRN medication expiry dates are checked monthly The rest home and hospital have a controlled drugs (CD) safe. There are weekly CD checks and a six monthly pharmacy audit occurs (last in November -13). The hospital wing holds a controlled drug stock for use in palliative care. The medication fridges are checked weekly and corrective actions (sighted) are taken when temperatures are outside of the acceptable range.  Sharps are disposed of into an approved sharps container. All medications in trolleys are within the expiry date and eye drops dated on opening. Healthcare assistants and RN's complete annual medication competencies and attend annual education provided by the supplying pharmacy. RNs attend syringe driver education and annual refresher with Hospice Marlborough. There is a current medication competent persons signing list and all staff sign the administration signing register. The signing administration charts are all correct. Times are recorded when prn medications are administered. There is a current standing order for household remedies. Self-medicating residents have a competency assessment completed by the GP. Monitoring the administration of medications for self-medicating residents occur. Two persons sign the administration form for CD's.  16 medication charts sampled had recent photograph identification and allergies documented. All medication charts have been reviewed three monthly.  Oxygen cylinders, oxygen concentrators and emergency equipment are checked weekly. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The main cook on duty has commenced Level 4 chef qualification. All food services staff have attended NZQA food safety and hygiene standards in June 13. There is a weekend/reliever qualified cook. The menu has recently been reviewed by Nutritional Consultants services and the menu is currently in week three. Feedback is sought from the residents. Recommendations included adding the milk base puddings to the menu and avoid the repetition of meals. The cook receives food and nutrition profiles for each resident and is informed if there are any dietary changes or requirements. Smoothies are provided daily for hospital level residents. A communication book is used between food services and clinical staff. All meals and baking is done on-site. Hot food temperatures are monitored daily. Food is served from the bain marie for residents in the rest home dining room. Meals are delivered in hot boxes to the hospital and serviced apartment-dining areas. Meals such as vegetarian and pureed are name labelled before delivery. The kitchen has a good workflow with delivery, storage, meal preparation, baking, serving and dishwashing areas. The kitchen is well equipped with gas hobs and oven, combi-oven and deep fryer. Dry goods are ordered weekly and there is rotation of foods on delivery. The pantry is tidy with all foods in sealed and labelled containers. Fridge, chiller and freezer temperatures are recorded daily. The cook was able to describe the action taken for temperatures outside of the acceptable range. All equipment has a current electrical test and tagged. The dishwasher is checked two weekly for function and temperature checks. Staff are observed wearing appropriate protective clothing. Kitchen cleaning schedules are maintained. XXXXX supply chemicals and safety data sheets. All chemicals are correctly labelled. The cook attends resident meetings, staff meetings and interacts with residents attending happy hours and receiving feedback on the service. Residents interviewed (six hospital and two rest home) state they enjoy the meals and home baking. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting incidents involving infectious material and hazardous substances. Approved sharps containers are available for the safe disposal of sharps. Staff interviewed are knowledgeable in the disposal of general and infectious waste. An external contractor collects the skip bin weekly. Recycling is taken to the local recycling centre. Chemicals are signed in on delivery to a main locked storage room and a record is kept of distribution to the service areas. All chemicals are labelled correctly. The chemical supplier provides safety data sheets and chemical safety training as required. There is a chemical spills kit available. 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. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 19 April 2014. An external contractor conducts monthly fire equipment checks.  The maintenance person is employed for 12 hours a week and carries out general maintenance requests and repairs. Preferred contractors are contacted for electrical, plumbing, building and other requirements. There is an annual planned maintenance schedule in place. All equipment is tested and tagged. Clinical equipment is checked for function and calibrated annually.  The hallways are wide and have hand rails appropriately placed. The outdoor areas are well maintained and easily accessible for the residents. There is shaded seating areas and raised vegetable gardens.  ARC D15.3;The following equipment is available, pressure relieving mattresses, roho cushions, electric beds, hoists and chair scales (last calibrated April 2013), walking frames, wheelchairs, resident transferring aids.  There is an improvement required around monthly hot water temperature monitoring. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a monthly maintenance checklist in place. |
| **Finding:** |
| There is no evidence of monthly hot water temperature monitoring. |
| **Corrective Action:** |
| Ensure hot water temperature monitoring is conducted monthly as per the monthly maintenance schedule. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms in the rest home and hospital wings are ensuited. The flooring is non-slip and there are handrails placed appropriately within the toilet and shower area. There is a call bell situated within reach for the residents. Residents interviewed stated the healthcare assistants respect their privacy and dignity when attending to their personal needs. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate space in all bedrooms for the residents to mobilise safely with the use of mobility aids. Healthcare assistants (interviewed) state there is sufficient room to move freely to provide cares with the use of a hoist. Doorways into residents' rooms and communal areas are wide enough for wheelchair and hoist use. Bedrooms viewed are personalized, spacious and fixtures and carpets well maintained. Residents interviewed 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 manoeuvre with the assistance of their aid within their personal space/bed area.

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are communal dining and lounge areas in the rest home and hospital level wings. There is sufficient space for recreational activities to take place.. The areas are welcoming and the décor provides a homely atmosphere. Seating is appropriate and placement allows for group or individual activities to take place. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The laundry is located away from the resident areas and operates from midnight to 9am. There is also a small domestic laundry for the kitchen washing only. The main laundry has an entry and exit door with defined clean and soiled linen areas. There are adequate linen supplies. Residents interviewed are satisfied with the laundry service stating the laundry staff take good care of their clothing. The laundry is well equipped and the machines are serviced regularly. The cleaning co-ordinator (interviewed) states there are two cleaning staff on duty each day. All staff have attended chemical safety courses. The cleaning co-ordinator is the infection control representative. Feedback on the service is received verbally and through resident meetings. Internal audits and resident satisfaction surveys identify any areas for improvement. Cleaning staff are observed wearing appropriate personal protective clothing. Cleaner’s trolleys are well equipped. All chemical bottles are correctly labelled. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. A fire evacuation was last held during October 2012, staff report that attendance was very good.  D19.6 there are emergency management plans in place to ensure health, civil defence and other emergencies are included. There is an approved evacuation plan dated 27/05/13. The facility is well prepared for civil emergencies and has centralised emergency supply store. A storeroom has been equipped with all supplies needed in the event of an emergency including PPE. A store of emergency tank water is available. There is a gas hob in the kitchen for cooking and emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available.  The call bell system is available in all areas and indicator panels in each area. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. Visitors sign in/out book at reception and the facility is secured at night. Residents interviewed stated their call bells were answered in a timely manner. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| General living areas and bedrooms are appropriately heated with under floor heating. The communal lounges have gas log fire heating as well. Residents and families interviewed confirmed the environment is warm and comfortable throughout the winter and there is adequate ventilation throughout the facility during the summer months. Windows and doors open out on to outdoor areas and gardens. All bedrooms have at least one external window. Communal areas and hallways have good natural lighting. |

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

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

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

##### **Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has comprehensive policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has nine residents assessed as requiring the use of restraint and two with enablers in the hospital wing. Restraint in use for hospital includes bedsides and lap belts. In the rest home; one resident has a bedside enabler. The care plans are up to date and include reference to the restraint/ enabler in use (link to 1.3.6.1 for care plan documentation and guidance for staff). Falls risk assessments are completed six monthly. Challenging behaviour assessments are completed as required. Policy dictates that enablers should be voluntary and the least restrictive option possible and six health care assistants, two registered nurses and the clinical nurse leader are familiar with this. Restraint meetings and audits are undertaken three times a year and are documented. Staff received training around restraint minimisation (February 2013) and the management of challenging behaviour/ de-escalation (March and May 2013). The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. |

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

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

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

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

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (clinical nurse manager) and one RN link nurse was able to describe the role and responsibilities.  One rest home resident file was reviewed (enabler) and three hospital resident files reviewed (two restraint, one enabler) specifically for resident process.’ All four resident file documented a completed consent form and completed assessment for restraint/ enabler form. Restraint meeting minutes reviewed (May and August 2013) and restraint audit reviewed documented that the service ensures that correct process is implemented by the service. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint minimisation policy outlines the organisation approach to managing restraint.  This includes the use of a restraint assessment guide by RN One rest home and three hospital files reviewed for restraint/ enabler practices all documented that an in-depth assessment had taken place which included the consideration of alternatives. |

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

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

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

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

Services use restraint safely

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The restraint minimisation policy has clear guidelines regarding the need for assessment and the monitoring needed for residents with restraint and / or enablers. The service requires that both enablers and restraints are monitored using the restraint monitoring form at least two hourly. Four resident files reviewed for restraint/ enabler practices all document that a monitoring form is used and that care plans direct the caregivers as to monitoring frequency (link improvements 1.3.6.1). Restraint is also reviewed as part of the resident care plan review process and GP review process. The restraint coordinator was able to show how two resident reviews have resulted in the safe removal of restraint. The service reviews all restraint use as part of the monthly meetings and through the three times a year restraint meetings. The restraint coordinator was able to discuss how restraint is only used as a last resort after all other alternative techniques to modify behaviour or manage resident safety has been exhausted. This is outlined as policy requirements in the Restraint Minimisation Policy.  The Restraint Minimisation policy requires that a restraint register is maintained with all residents’ names and restraint details included. The restraint register is maintained and updated by the restraint coordinator as required. Staff training records are maintained and individual participation in restraint training is identified. Restraint competencies are completed by all care staff and registered nurses. |

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The use of restraining devices is evaluated by the restraint coordinator (clinical nurse manager) and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and GP. Points a) to k) above are considered as part of this review. On review of four files, evaluations are completed. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Springlands Village reviews the use of restraint as part of its internal audit processes. Restraint audit for July 2013 documents that competencies were overdue for some staff and this is now in the process of being rectified and some documentation omissions have also been rectified. The service is proactive with reviewing restraint use and working towards reducing the use of restraint. The results of the restraint audit are discussed at the monthly meetings and three times a year restraint meetings. Any corrective actions identified are actioned through these meetings. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control team is led by the clinical nurse manager with a registered nurse for each of the rest home and hospital wings acting as ‘link nurses for the areas. The infection control policy identifies clearly the roles of the IC nurse and supporting team. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through two monthly staff meetings. Staff are informed about IC practises and reporting through staff meetings, training and information posted up on staff notice boards. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC nurse and entered into the infection register. The service has developed strong links with the public health service with a member of this service providing training to staff and advice as needed. Recent D and V outbreak documents liaison with public health and a swift resolution to the outbreak. Two residents with ESBL have well documented care plans and HCAs are aware of the care and precautions in place. Care precautions for these two residents include resident specific equipment which is colour coded to ensure exclusivity. There is a job description for the IC nurse including the role and responsibilities of the infection control coordinator. There are policies and an infection control manual to guide staff to prevent the spread of infection. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical nurse manager provides an IC report to the monthly infection control meeting, the monthly management meeting, the monthly RN and the two monthly quality meetings (minutes reviewed).  The IC nurse can access external DHB, IC nurse specialist and GP's specialist advice when required. There are strong links developed with public health service There is a documented annual review of the IC policy dated September 2013. The IC nurse complies with the objectives of the infection control policy and works with all staff to facilitate the programme. She has attended IC training provided by the DHB.  Staff complete annual infection control competencies annually and these are documented in staff files reviewed. Staff training has been provided by Med Lab (March 2013) and hand hygiene (August 2013). There is also a documented ‘shoulder tap’ hand-washing database to ensure that all staff have an observed review of their technique annually. The IC nurse has access to all relevant resident information to undertake surveillance, audits and investigations. The service audit programme includes IC audits three times a year. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Springlands has infection control policies and an infection control manual through an external provider which reflect current practise.  D 19.2a: Infection control policies include hand hygiene, standard precautions, transmission-based precautions, outbreak management, antimicrobial usage, prevention and management of infection. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All new staff receive infection control education at orientation including hand washing and preventative measures.  Infection control education was delivered in March 2013 and August 2013).  The service records education session content, attendance records and competency.  External resources, including DHB and public health department, ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine.  There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until better. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the IC nurse officer (the clinical nurse manager); she is supported by an RN link nurse from each of the hospital and rest home wings. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities are appropriate to the acuity, risk and needs of the residents.  All infections are collected and collated monthly and entered on to the infection register and computer database which generates a monthly analysis of the data. IC data is reported by rest home and hospital. There is evidence that results of surveillance out comes are acted upon as evidenced by IDC removal following a history of high UTIs (resolved problem) and education re hand hygiene following eye infections (resolved problem). ICU analysis includes graphs and trend analysis and is reported to the monthly staff, RN and management meetings and also the quality meetings that include a cross section of staff (minutes viewed). The IC officer uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Monthly management reports to the GM and directors were also evidenced. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. There is evidence of GP involvement and laboratory reporting. |

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

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

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

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

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

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