# Merivale Lifecare 2011 Limited

## Current Status: 9 December 2013

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

## General overview

Merivale Retirement Village provides rest home and hospital (geriatric and medical) level care for up to 102 residents. On the day of the audit there were 52 residents at rest home level care (including five rest home residents in the serviced apartments) and 30 residents at hospital (geriatric) level care. The service is managed by the owner manager (a general practitioner) with a nurse manager who has been in the role for thirteen months. She is supported by a team of registered nurses.

Improvements are required to the following: care planning, including wound management, care plans, interventions and prescribing of medications.

## Audit Summary as at 9 December 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 9 December 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 9 December 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 9 December 2013

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

### Safe and Appropriate Environment as at 9 December 2013

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

### Restraint Minimisation and Safe Practice as at 9 December 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 9 December 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 9 December 2013

### Consumer Rights

Merivale Retirement Village strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. 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 easily accessible to residents and families. Policies are implemented to support residents’ rights. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

### Organisational Management

Merivale Retirement Village has a quality and risk management system implemented. Key aspects of the quality improvement and risk management programme include review of the business plan, monitoring of incidents and accidents, key performance indicators, infection control, restraint use, satisfaction surveys, incidents, health and safety, hazards and implementation of an internal audit schedule. The service has policies and procedures that have been reviewed in 2013. The service has human resources policies and procedures implemented for staff recruitment and employment and there is an implemented orientation programme and annual training schedule that has been reviewed to include self-learning questionnaires. Staffing levels safely meet the needs of the residents.

### Continuum of Service Delivery

The service has admission and entry 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 was discussed with them. Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provide evidence that the registered nurse has completed an initial assessment and care plan on admission and long term care plans are developed within three weeks of admission. 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 or earlier due to health changes. There are three monthly multidisciplinary reviews. Risk assessments tools are available. Care plans demonstrate service integration and guide all staff in cares. There are improvements required around interventions, wound management and care plans. The GP examines the resident within 48 hours of admission and three monthly thereafter. Resident files are integrated and include notes by the GP and allied health professionals.

There are policies and procedures for medicine management. Registered nurses and senior caregivers 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 GPs review the medication records three monthly. There is an improvement required around medication prescribing.

A diversional therapist and an activities co-ordinator facilitate the activities programme. Separate programmes are delivered for rest home and hospital residents that meet each of the consumer group’s physical and cognitive abilities. Residents and families have input into the activity programme. Links with the community are maintained and van outings are arranged on a regular basis.

All food is cooked on site in the main kitchen and served from the kitchenettes in hospital and serviced apartments. Residents' nutritional needs are identified and accommodated with alternatives provided. Meals are well presented, homely and a dietitian has reviewed the menu plans. The food service manager oversees the food service. All staff are qualified and have undertaken food safety and hygiene and chemical safety 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 safe storage of chemicals in the cleaning, laundry and kitchen areas. There is correct labelling of chemical bottles. A chemical spills kit is readily accessible. Appropriate protective equipment and clothing is available for staff. The interior of the home is spacious, light and clean. The rest home and hospital buildings hold a current building warrant of fitness. Residents interviewed state the facility is warm and comfortable in winter and adequately ventilated in summer. Planned internal and external maintenance schedules are in place. Clinical equipment is serviced annually. Hot water temperatures are monitored monthly. The external gardens and grounds are well maintained, accessible and safe for residents and family members.

### Restraint Minimisation and Safe Practice

The service does not use restraint and there is one enabler used appropriately. All staff have had training around management of challenging behaviours, restraint and enablers. There are appropriate procedures to follow in the event that restraint was required.

### Infection Prevention and Control

Infection control policies and procedures are documented. The infection control co-ordinator (nurse manager) is responsible for implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery. Discussion around infection control occurs through management and staff meetings including the registered nurse meetings.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## 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:** | Merivale Lifecare 2011 Limited |
| **Certificate name:** | Merivale Lifecare 2011 Limited |

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| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Merivale Retirement Village | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 9 December 2013 | **End date:** | 10 December 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:** | 82 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 9 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 7 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 18 | Total audit hours | 50 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 11 | Number of staff interviewed | 16 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 11 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 101 | 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited 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) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Friday, 10 January 2014

## Executive Summary of Audit

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| **General Overview** |
| Merivale Retirement Village provides rest home and hospital (geriatric and medical) level care for up to 102 residents. On the day of the audit there were 52 residents at rest home level care (including five rest home residents in the serviced apartments) and 30 residents at hospital (geriatric) level care. The service is managed by the owner manager (a general practitioner) with a nurse manager who has been in the role for one year and one month. She is supported by a team of registered nurses.  Improvements are required to the following: care planning, including wound management, care plans, interventions and prescribing of medications. |

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| **Outcome 1.1: Consumer Rights** |
| Merivale Retirement Village strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. 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 easily accessible to residents and families. Policies are implemented to support residents’ rights. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained. |

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| **Outcome 1.2: Organisational Management** |
| Merivale Retirement Village has a quality and risk management system implemented. Key aspects of the quality improvement and risk management programme include review of the business plan, monitoring of incidents and accidents, key performance indicators, infection control, restraint use, satisfaction surveys, incidents, health and safety, hazards and implementation of an internal audit schedule. The service has policies and procedures that have been reviewed in 2013. The service has human resources policies and procedures implemented for staff recruitment and employment and there is an implemented orientation programme and annual training schedule that has been reviewed to include self-learning questionnaires. Staffing levels safely meet the needs of the residents. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has admission and entry 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 was discussed with them. Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provide evidence that the registered nurse has completed an initial assessment and care plan on admission and long term care plans are developed within three weeks of admission. 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 or earlier due to health changes. There are three monthly multidisciplinary reviews. Risk assessments tools are available. Care plans demonstrate service integration and guide all staff in cares. There are improvements required around interventions, wound management and care plans. The GP examines the resident within 48 hours of admission and three monthly thereafter. Resident files are integrated and include notes by the GP and allied health professionals.  There are policies and procedures for medicine management. Registered nurses and senior caregivers 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 GPs review the medication records three monthly. There is an improvement required around medication prescribing.  A diversional therapist and an activities co-ordinator facilitate the activities programme. Separate programmes are delivered for rest home and hospital residents that meet each of the consumer group’s physical and cognitive abilities. Residents and families have input into the activity programme. Links with the community are maintained and van outings are arranged on a regular basis.  All food is cooked on site in the main kitchen and served from the kitchenettes in hospital and serviced apartments. Residents' nutritional needs are identified and accommodated with alternatives provided. Meals are well presented, homely and a dietitian has reviewed the menu plans. The food service manager oversees the food service. All staff are qualified and have undertaken food safety and hygiene and chemical safety 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 safe storage of chemicals in the cleaning, laundry and kitchen areas. There is correct labelling of chemical bottles. A chemical spills kit is readily accessible. Appropriate protective equipment and clothing is available for staff. The interior of the home is spacious, light and clean. The rest home and hospital buildings hold a current building warrant of fitness. Residents interviewed state the facility is warm and comfortable in winter and adequately ventilated in summer. Planned internal and external maintenance schedules are in place. Clinical equipment is serviced annually. Hot water temperatures are monitored monthly. The external gardens and grounds are well maintained, accessible and safe for residents and family members. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service does not use restraint and there is one enabler used appropriately. All staff have had training around management of challenging behaviours, restraint and enablers. There are appropriate procedures to follow in the event that restraint was required. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control policies and procedures are documented. The infection control co-ordinator (nurse manager) is responsible for implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery. Discussion around infection control occurs through management and staff meetings including the registered nurse meetings. |

## Summary of Attainment

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 42 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 3 | 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 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | i)Two Maori residents who identify as Maori do not have cultural preferences documented in the long term care plan.  ii)One diabetic resident’s care plan does not define “optimal blood sugar” levels or diabetes management for hypo and hyperglycaemic levels. | Ensure care plans reflect the residents required support for cultural and medical needs. | 60 |
| 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) Corrective actions documented post falls for two residents are not reflected in the long term care plan.  ii) Eight of 20 wound assessment/short term care plans are incomplete. Four wound assessments haven signature of the person carrying out the assessment, two have no description of size, three have no location on the body map and one wound assessment does not identify the type of wound. Wound assessment forms do not include medical conditions and contributing factors that could affect healing progress.  iii) a) There is no pain assessment for a rest home resident with pain on change of wound dressings. b) Management of pain and interventions for one rest home resident as identified at care plan review and physiotherapist assessment are not included in the long term care plan. c) Pain assessment for one hospital resident with on-going pain has not been reviewed three monthly. iv) There is no challenging behaviour assessment for the hospital resident on behaviour monitoring. There is no specific written evaluation around challenging behaviour. | i)Ensure corrective actions identified post falls are documented in the resident’s long term care plan.  ii)Ensure wound assessments are fully completed. The wound assessment form could be more comprehensive.  iii)Ensure pain assessments are completed for residents who identify pain. Ensure and needs and interventions for pain management are reflected in the resident care plan.  iv)Ensure challenging behaviour assessments are completed and reviewed for residents with challenging behaviour as per policy. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Five of 18 medication charts did not have a GP signature for a) discontinued medications (four charts) b) newly prescribed medication (one chart) and c) one chart did not have a controlled drug discontinued that is not in use. | Ensure GP prescribing meets legislative prescribing requirements. | 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 code of health and disability rights is incorporated into care.  Discussions with six caregivers (one from the serviced apartments, one rest home, two hospital and two who work across both hospital and rest home), the owner/manager, the nurse manager and the activities coordinator identified their familiarity with the code of rights.  A review of nine of nine resident files (four rest home including one form the serviced apartments and five hospital), two monthly resident meetings and monthly staff meetings confirms that the service functions in a way that complies with the code of rights.  Training around the code of rights and complaints was last provided in November 2013.  The auditors noted respectful attitudes towards residents on the day of the audit and 11 of 11 residents (seven hospital and four rest home including one from the serviced apartments) confirm that they are treated with respect and dignity with staff 'going the extra mile'. The resident meeting minutes confirm discussion of the code and of advocacy services and one hospital family member who attends the meetings states that there are regular reminders of rights and advocacy services. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy around resident rights that includes roles and responsibilities.  D6,2 and D16.1b.iii The information pack provided to potential residents pre-entry and the pack provided to residents on entry includes how to make a complaint, advocacy services and the code of rights.  The code of rights pamphlet, advocacy pamphlet and information around the Health and Disability Advocacy service is stated by the nurse manager as being given when residents and family come to look at the service - in the welcome packs sighted.  Code of rights leaflets and advocacy pamphlets are available in the service.  Code of rights posters are on the walls in the service.  If necessary, staff will read and explain information to residents as stated by the nurse manager. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.  Eleven of 11 residents and six of six family members interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process. |

##### 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:** |
| D3.1b, d, f, i The service has a philosophy that is 'to provide total care for our residents and improve their independence in an environment where respect, dignity and privacy are upheld at all times’.  There are policies around independence, personal privacy, dignity and respect and these are referenced to the Privacy Act.  D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. The welcome pack includes a property list for the resident/family to complete as they enter the service and this is then filed in the resident file.  D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified in the assessment and activity planning process.  Eleven of 11 residents (seven hospital and four rest home including one from the serviced apartments) interviewed state that they receive respectful care and support. All state that staff knock before they enter the room and this was observed to occur on the day of the audit.  Eleven of 11 residents and six of six family members (three rest home and three hospital) interviewed as well as six caregivers and the five registered nurses (one nurse manager, two charge nurses and two registered nurses) state that there is no evidence of abuse or neglect of residents. Training around neglect and abuse was last provided in November 2013. There are religious services weekly including Catholic, Anglican and Presbyterian. Staff including the caregivers interviewed state that residents are encouraged to attend their own church in the community whenever possible. One family member and one resident stated that a key reason for choosing the service initially was for the emphasis and importance placed on providing church services. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D20.1i There is a named Maori minister (Ngai Tahu) who provides support for the service.  A3.2 There is a cultural safety and Maori health policy that includes that the service is committed to providing services that are culturally safe and sensitive for all cultures. The policy documents safe practices for Maori including cultural and spiritual aspects of death and dying, Maori health and obligations under the Treaty of Waitangi, Maori concepts and ideology and Maori health consultation networks. Maori health groups and other providers are documented phone/email documented.  The Maori minister has input into the service as requested by the service and also provides cultural training in two sessions for staff (last provided in November 2013 with the final session planned for December 2013). The minister is able to bless rooms for the service when required. There are two residents who identify as Maori with one expressing a wish to keep connections with family. One other states that there are no special needs in relation to cultural needs identified. The assessments identify iwi, hapu and key whanau links with a comment in one in the assessment stating that the resident is ‘proud to be Ngai Tahu’. There are no special interventions documented in the care plan (refer 1.3.5.2). Family members are encouraged to visit and visitors were sighted coming and going on the day of the audit. Staff and managers state that this includes Maori families as well as all other cultures. |

##### 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:** |
| There is a culture cues guide for different cultures documented.  D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and any needs are included in the activities plan and review.  There are no residents with specific cultural needs as stated by the nurse manager and six caregivers interviewed although all were able to give examples of how cultural needs had been met for past residents.  D4.1c Nine of nine resident files (four rest home including one from the serviced apartments and five hospital) reviewed include the residents social, spiritual, cultural and recreational needs and this is consistently documented.  During the admission process, the nurse manager along with the resident and family complete the documentation. Reviews are evident in the files reviewed. There are no residents who identify as requiring an interpreter however the nurse manager is able to describe how an interpreter would be accessed through the DHB. In the last year there has been one resident with limited English and the nurse manager describes accessing the family and staff to interpret. There is a list of languages staff speak.  Staff were observed on the day of the audit to respect resident values by asking for their opinion and giving resident’s choice. Six of six family members interviewed felt that they were involved in decision making around the care of the resident and state that staff respect cultural beliefs and individual values. This was confirmed by the 11 residents interviewed. |

##### 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:** |
| Discrimination, harassment, professional boundaries and expectations are covered in the house rules that all staff are required to read and sign before commencing employment and the human resource policy that describes this in more depth. Staff can describe how professional boundaries are maintained including not taking gifts. Discussions with the nurse manager and a review of the complaints register identify that there have been no complaints regarding alleged harassment, coercion, discrimination or abuse of any kind.  Staff have training in abuse and neglect - last provided in November 2013.  Eleven of 11 residents and six of six family members interviewed state that there is no evidence of abuse or neglect and all state that there is no evidence of discrimination or harassment. |

##### 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:** |
| A2.2 Merivale Retirement Village has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The owner/manager has reviewed all policies in the past year and staff sign to state that they have read amendments. These are attached to monthly staff newsletters.  There is an implemented quality improvement programme that includes performance monitoring against key performance indicators.  D1.3 All approved service standards are adhered to noting that there are some standards in this audit that are identified with improvements required. D17.7c. There are implemented competencies for caregivers and registered nurses.  There are clear ethical and professional standards and boundaries within job descriptions. Eleven residents spoke very positively about the care and support provided and six family members also agreed that the care provided was good with family members using words to describe the service as ‘splendid’, ‘great care’, ‘no areas for improvement’, ‘no reason to complain’. Staff described a positive atmosphere and stated that they had access to resources that assisted them in providing care to residents.  The nurse manager is supported by two charge nurses (one in the rest home and one in the hospital) and the owner/manager who supports oversight and implementation of the quality programme.  The owner/manager describes recent improvements as being a focus on training that is now accessible to all staff through the implementation of questionnaires, implementation of the reviewed quality audit schedule with registered nurses now having more understanding of quality improvement through their involvement in the programme and the development of a board that now provides a governance role.  The service is using interRAI to document assessments and plans for residents.  Six caregivers (one from the serviced apartments, one rest home, two hospital and two who work across both hospital and rest home) have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education. All interviewed have completed eight ACE qualifications and or the national certificate. |

##### 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:** |
| 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 first contact with the family/resident.  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 through the agreement and in discussion with the nurse manager or registered nurse.  D16.4b Six of six relatives state that they are always informed when their family members health status changes. The facility has an interpreter policy and procedures available for access to interpreter services and residents (and their family) are provided with this information at the point of entry. Interpreters are available through the DHB if required. There have been no residents who require interpreting services. D11.3 The information pack is available in large print if required and advised that this can be read to residents.  Eleven of 11 residents (seven hospital and four rest home including one from the serviced apartments) interviewed and six of six family members interviewed (three hospital and three rest home) state that there is good communication with the nurse manager and charge nurses.  All family members state that they are informed when there is an incident and the incident forms reviewed (13 of 13 reviewed reflects this). |

##### 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:** |
| Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. An informed consent policy and procedure direct staff clearly in relation to the gathering of informed consent. Residents' rights training was last provided November 2013. Interviews with six caregivers (one from serviced apartments, one rest home, two hospital and two who work in the rest home and hospital) identify that consents are sought in the delivery of personal cares. A sample of nine resident files all included signed consent forms for receiving and sharing of personal information; to deliver care and support based on assessed needs; treatment and care to be delivered as assessed; to take photograph for the purpose of identification and display; to be transported on outings; to involve family/whanau in care planning and delivery of care; routine procedures; removal of perishable goods from rooms as required and the wearing of a wrist band if necessary. There is a resuscitation consent policy and a resuscitation consent form. Residents who are deemed competent to sign a resuscitation decision form indicate whether they wish to be resuscitated. The advance directive also includes directives for interventions for a) acute exacerbation of current condition or separate illness b) serious difficulty feeding and c) violent and degenerative behaviour. A sample of nine resident files identified resuscitation consent forms are completed appropriately.  D13.1: There were nine admission agreements sighted and six been signed on the day of admission. Follow-up phones calls/letters and email reminders are sighted for three of the admission agreements. One agreement was sent to a lawyer before being returned.  D3.1.d: Discussion with six family identified that the service actively involves them in decisions that affect their relative’s lives. Four rest home residents and seven hospital residents interviewed confirmed they were consulted and given information to enable them to make informed decision regarding their care. |

##### 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:** |
| The code of rights policy and advocacy policy identifies that the resident can access advocacy services, and contact numbers are documented.  The Merivale Retirement Village information pack includes a section around access to advocacy services with the pamphlet around the Nationwide Advocacy Service included.  Staff including the six caregivers and the nurse manager are aware of advocacy services and can describe how to access an advocate. D4.1d; Discussion with six family identifies that the service provides opportunities for the family/EPOA to be involved in decisions  Residents are informed of their right to advocacy services as part of the admission process and thereafter if there are complaints raised. A family member acts as an advocate for residents and visits the residents to identify any issues or concerns. These are then fed back to the nurse manager or to the owner/manager as appropriate.  The nurse manager takes a right from the code of rights to discuss at each two monthly resident meeting and reference to the advocacy services are also described. One family member confirmed that information around advocacy services is given at this meeting. |

##### 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:** |
| D3.1h; Discussion with six of six family indicate that they are encouraged to be involved with the service and care. D3.1.e Discussion with six caregivers, the nurse manager, the owner/manager and six of six relatives confirmed that the service supports and encourages residents to remain involved in the community and external groups.  There are progress notes and these record communication with family. Visitors were sighted coming and going on the days of the audit and were welcomed into the service.  All family members interviewed state that they are always made to feel welcome and a part of the service. |

##### 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:** |
| D13.3h. The service has complaints management policies and procedures in place and residents are provided with information on the complaints process on admission through the information pack. D13.3g: The complaints procedure is provided to relatives on admission as confirmed by six of six family interviewed. The complaint process is in a format that is readily understood and accessible to residents/family.  Staff including the six caregivers are aware of the complaints process and to whom they should direct complaints. Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary. One family member states that in the past a complaint has been made and this was resolved in a timely manner.  There is a comprehensive electronic complaints register in place. Four complaints reviewed in September 2013 are documented on the complaints register and all tracked indicate that resolution and a letter to the complainant has been completed in a timely manner.  The owner/manager confirms that there have been no complaints in the past three years with the Health and Disability Commissioner, MoH or DHB. |

##### 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:** |
| Merivale Retirement Village provides rest home and hospital level care (geriatric and medical) for up to 102 residents including 48 rest home beds, 35 hospital/medical beds and 19 serviced apartments in the same building as the rest home that can be used as rest home beds. Occupancy on the days of the audit is 83 including 52 rest home residents (including five in the serviced apartments) and 30 hospital residents.  Merivale Retirement Village has a business plan that includes strategic direction (strengths, weaknesses, opportunities and threats documented), strategic objectives and a business plan that includes objectives, strategy, measures and timeframes. The business plan is reviewed annually at the management meeting. The owner/manager (a general practitioner (GP)) visits the service most days and as required and is fully available via internet and phone with the nurse manager stating that the owner/manager is also available when away on leave.  The mission statement is documented and there is a pamphlet describing the service. The welcome pack also includes an outline of the hospital part of the service with another describing the rest home area.  A governance board oversees the service. This has recently been set up with four members of the consortium on the board. There is a terms of reference documented and minutes indicate that the board meets two monthly (August, October, December meeting minutes sighted).  The board ratifies key documents such as the policies and procedures and the owner/manager confirms that any key incidents/complaints/health and safety issues are escalated to the board for discussion. |

##### 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:** |
| The owners are part of a consortium and the governance board will continue to meet even if the owner/manager on site is away. The nurse manager is the second in charge in the absence of the owner/manager and the owner/manager confirms the appropriateness of this. There are two charge nurses – one for the hospital and one in the rest home. They provide support and cover for the nurse manager as does the owner/manager )(a GP) when the nurse manager is away.  The organisational chart documents the structure. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.1a; A review of the documentation, policies and procedures and from discussion with the owner/manager, nurse manager, registered nurses including the charge nurses and caregivers identifies that there are service operational management strategies and an implemented quality and risk programme which includes individually appropriate care. The owner/manager is now taking responsibility for the quality programme with the nurse manager taking a key clinical role. The meeting structure and audit schedule along with policies and procedures have been reviewed in 2013 to increase oversight of the service.  The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and these are reviewed annually to two yearly by the owner/manager with support from other members of the management team.  There is a document control process in place for all policies.  D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures. Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety. D10.1 There is a death policy and procedure that outlines immediate action to be taken upon a resident death and that all necessary certifications and documentation is completed in a timely manner. The six caregivers interviewed state that any new caregiver receives an orientation that includes reading of the policies - orientation records signed off in all 11 staff files reviewed and any new policies are included at meetings and as part of the monthly staff newsletter with staff signing to state that they have read amendments to policies.  The service has an implemented internal audit programme reviewed in 2013 and when issues are identified, there is evidence in the meeting minutes that these are followed up and issues resolved.  There are a range of meetings held throughout the service to ensure that all staff are linked into and have responsibilities around the quality programme. These include the following: two weekly management, quarterly full staff, monthly caregiver (individually for rest home, hospital and night staff), monthly registered nurse/enrolled nurse, weekly charge nurse/nurse manager, two monthly restraint, two monthly health and safety, two monthly infection control, monthly quality, six monthly household (individual meetings including kitchen, laundry and cleaning), monthly activities. The set agenda ensures that all aspects of the quality and risk programme are discussed i.e. infections and infection control, complaints, incidents and accidents, staff, resident issues.  Resident meetings are held monthly in the rest home and two monthly in the hospital. Family are invited to attend and one family member in the hospital spoke of the usefulness of the meetings. These also serve to remind residents/family around the code of rights and advocacy.  There is a risk management register and hazards documented. A review of these indicate that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents. There are resident newsletters that are aimed at ensuring that residents are kept informed of any changes in the organisation.  Residents and family complete an annual satisfaction survey (last completed in 2013) with evidence that all who responded are very satisfied. The activities satisfaction survey has also been completed in 2013 with 100% satisfaction.  Any corrective actions that arise from the satisfaction survey or from resident meetings are put onto the complaints register and addressed as per the complaints policy. Issues raised from both were sighted on the complaints register and addressed in a timely manner.  D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g Falls prevention strategies such as sensor mats, fall out mattresses, increased supervision, hourly monitoring if required, one to one support if required (occurred for one resident in 2013 as described by the nurse manager), increased physical activity, low beds. Relevant residents had these strategies identified in care plans and staff including the charge nurses, registered nurses, nurse manager and caregiver are able to describe individual residents and strategies implemented.  Corrective action plans are documented for any issues identified and signed off as resolved in a timely manner.  Residents and family interviewed can describe improvements in the service over the past year. |

##### 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; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  Incidents/accidents are investigated and analysis of incidents trends occurs monthly. There is a discussion of incidents/accidents in relevant meetings including staff, registered nurse, charge nurse and management meetings.  Discussions with the nurse manager and the owner/manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public Health were notified of a norovirus outbreak in November 2012. A review of 13 incident forms indicate that all have been signed off by the charge nurse and/or nurse manager and all indicate that family have been informed (refer 1.3.6.1). |

##### 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:** |
| Eleven staff files were reviewed including the nurse manager, three registered nurses including two charge nurses, one cleaner, one chef, three caregivers, one activities coordinator and one diversional therapist.  D17.7d: There are implemented competencies for all relevant caregivers and registered nurses around medication and evidence in 11 of 11 staff files confirm that these have been completed for relevant staff.  Current practicing certificates are sighted for the nurse manager (registered nurse), all registered nurses/enrolled nurse, doctors, dietician and physiotherapist.  Eleven of 11 staff files include a signed contract, application form, evidence of training, referee checks, police checks and job description.  Eleven of 11 files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home and hospital level care - confirmed by the new member of staff who described having a buddy for three days.  Caregivers have completed ACE or national certificate for aged care training.  The nurse manager, owner/manager and registered nurses confirm that they have completed at least eight hours training a year (training records sighted for the nurse manager).  Eleven of 11 residents and six of six family members interviewed state consistently that staff are competent, caring and knowledgeable. The service has reorganised training over the past year to increase the uptake of training for staff. The training plans now include face to face group sessions offered monthly and self-learning tools developed for each aspect of the standards. Caregivers interviewed confirmed that they found the training valuable and that the opportunity to complete the self-learning tools in their own time within a two week timeframe. |

##### 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:** |
| There are policies, systems and a roster in place that meets the requirements of the contract and supports safe staffing levels for service delivery. There are human resource policies in place that outlines staffing responsibilities, staff levels and skill mix of the rest home, 24 hour on call management availability.  There are 101 staff including the nurse manager and owner/manager, 55 caregivers, maintenance, activities coordinator and diversional therapist, chef and cook, 13 kitchen hands, two charge nurses, two gardeners, one physiotherapist (minimum eight hours a week), eight registered nurses, one enrolled nurse, nine household staff (seven days a week).  There is a roster in place that meets the contract requirements - sighted with evidence that staff are replaced if off sick.  On call is managed by the nurse manager with support from the charge nurses and registered nurses are required. There is also a caregiver on call who can come in when required if additional staff are required.  Rest home: There are two floors with rest home beds and the serviced apartments are on the second floor along from the rest home beds. On the morning and afternoon shifts there are five caregivers (two first floor, two ground floor and one serviced apartments with a full and short shift on each floor) and two full shift on night duty (one on ground and one on the first floor).  Hospital: The hospital is in a building next door separated by a path and there is only one floor. There are seven AM caregivers (four full and three short), five PM caregivers (two full and three short) and a caregiver overnight. There is a registered nurse on each shift seven days a week in the hospital, a registered nurse on AM in the rest home. There is a charge nurse for the rest home and hospital rostered from Monday to Friday.  The nurse manager provides oversight of all clinical aspects of service delivery.  The two caregivers interviewed who have done night duty confirm that they can access the on call staff including the on call caregiver if extra staffing is required. Staff interviewed confirm that the roster provides adequate cover. There is a low staff turnover in the hospital and a higher staff turnover in the rest home (staff moving from Christchurch or family reasons).  Both residents, family and staff interviewed confirm there are sufficient staffing levels to meet resident’s needs. The caregivers are aware of when to call emergency services and can describe escalation of any concerns to the registered nurse. |

##### 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:** |
| The service retains relevant and appropriate information to identify residents and track records. This includes information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service. There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records.  Files and relevant resident care and support information can be accessed in a timely manner. D7.1 Entries are legible, include dates and are signed by the relevant caregiver, registered nurse, staff member or manager including designation. Individual resident files demonstrate service integration (nine of nine reviewed). This includes medical care interventions and records of the activities officer. Medication charts are in a separate folder with medication and this is appropriate to the service. There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and online resident data base. Resident records are integrated and include resident personal details, nursing documents, medical notes, allied health professional progress notes, discharge summaries, referral/specialist records and letters, and needs assessment approval for level of care. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access.  D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Progress notes are written every shift in the hospital and at least daily in the rest home and when significant events occur. Care plans (computer generated or InterRAI), notes are legible, and where necessary signed and dated.  Policies contain service name, date of issue and review date. |

##### 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. Enquiry forms are completed and forwarded to the nurse manager (NM) who screens all potential enquiries to ensure the client meets the level of care that is provided by the service. Potential clients are invited to view the facility and receive an information pack. Currently there is a waiting list for rest home beds or where clients are waiting for a specific room. The NM maintains an online database and follows up clients on the waiting list regularly.  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 nine resident files (four rest home and five hospital) 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:** |
| 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. Potential clients can be placed on an internal waiting list. |

##### 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 nine files reviewed (four rest home and five hospital) identified that in all nine files an assessment was completed within 24 hours and all nine 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 (RN) and amended when current health changes. Evaluations are completed three monthly for hospital residents and six monthly for rest home residents.  There is a verbal handover for all oncoming shifts and a written handover sheet detailing the resident diagnosis, mobility status, cares and any significant events. There is also an RN to RN handover in the hospital facility. There is an RN/enrolled nurse (EN) and team leader communication diary with entries regarding appointments, medical tests, supplies required. There is a dietitian and a physiotherapist communication book for referrals and information that ensures continuity of service. Clinical progress notes, medical and allied health notes are maintained in the resident’s integrated file.  D16.5e: Nine resident files reviewed identified that the general practitioner (GP) had seen the resident within two working days. It was noted in resident files reviewed that a GP review stamp is used and signed by the GP to confirm the resident as stable and is to be seen three monthly or earlier if required.  The GP from a local practice (interviewed) is contracted to provide medical services for the residents in the rest home and hospital. The GP visits weekly for three monthly visits and visits any other resident of concern. The GP is available by mobile, text, fax and telephone advice at any time. The GP meets with families during the rounds if necessary to discuss medical concerns, advance directives and future treatments. The GP attended to a new admission transferred from hospital on the same afternoon, assessed the resident and completed a medication chart. Current GP practicing certificates are sighted.  The service employs a physiotherapist for eight hours a week. The physiotherapist (interviewed) completes a physiotherapist assessment and mobility chart on all new residents. The physiotherapist is involved in the multidisciplinary reviews. There is a physiotherapist communication book for all staff to access and the physiotherapist records visits and treatments into the allied health progress notes in the integrated file. Residents are assessed to attend the physiotherapist advanced exercise classes that are focused on improving balance. The physiotherapist is involved in the post falls corrective action.  RN’s and caregivers have attended relevant clinical in-service such as; blood sugar monitoring, manual handling and use of hoist, delirium, challenging behaviour, first aid and cultural training.   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 level 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, and social history.  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 evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives (three rest home and three hospital) and residents (four rest home and seven hospital) 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);  a) health status and clinical risk b) continence assessment c) Waterlow pressure area risk d) coombes fall risk and mobility chart e) nutritional assessment f) pain assessment and g) wound 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:** PA Low |
| **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. InterRAI care planning is in place for rest home residents. Computer generated care plans are developed for hospital care residents. There is documented evidence that the resident/family/whanau/diversional therapist (DT)/RN/senior carer and physiotherapist are involved in the development and review of care plans.  The integrated resident file also contains the admission documentation, informed consent forms and advance directives, enduring power of attorney (EPOA), family contact record, care documents, risk assessment tools and reviews, nursing progress notes, 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, incidents/accidents, referral letters and correspondence and needs assessment approval.  D16.3k, Short term care plans are available for use to document any changes in health needs. Short term care plans are evidenced for nausea, minor wound, UTI, eye infection, chest infection and weight loss.   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 records sighted in the resident individual record evidenced family are informed of any health changes, incidents/accidents, infections, GP visits, referrals, specialist visits, care plan reviews. An improvement is required to ensure care plans reflect resident’s current support for cultural and medical needs. |

##### 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:** PA Low |
| **Evidence:** |
| InterRAI care planning is in place for rest home residents. Computer generated care plans are developed for hospital care residents. There is documented evidence that the resident/family/whanau/DT/RN/senior carer and physiotherapist are involved in the development and review of care plans. There is a Maori health plan in place. Caregiving staff are knowledgeable in Maori culture, sensitivity and awareness in delivery of care. Staff have attended cultural training in November 2013. |
| **Finding:** |
| i)Two Maori residents who identify as Maori do not have cultural preferences documented in the long term care plan.  ii)One diabetic resident’s care plan does not define “optimal blood sugar” levels or diabetes management for hypo and hyperglycaemic levels. |
| **Corrective Action:** |
| Ensure care plans reflect the residents required support for cultural and medical needs. |
| **Timeframe (days):** 60 *(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 interviewed reported the resident’s 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 NM 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 (rest home and hospital) 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. Staff attended continence management July 2013. Nutritional assessments are completed on admission and reviewed at least six monthly or earlier if required. Residents are weighed monthly on chair scales in the rest home and wheel-on scales in the hospital. Scales were calibrated in May 2013. An on-line database of resident’s weight identifies trends and body mass indicators that require corrective actions for weight loss or gain. A short term care plan for weight loss post hospital admission includes interventions of fortnightly weigh, re-assessment of food dislikes and likes, high calorie diet, dietary supplement (such as smoothies twice daily). The GP is notified of any residents weight loss and all resident weights are reviewed at least three monthly by the GP. There is evidence of dietitian referral for the resident with unintentional weight loss. 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 documented on the accident/incident forms and post falls corrective action forms include; ultra-low beds, sensor mats, the wearing of good fitting footwear, ensuring rooms are not cluttered, use of night-lights, exercise programmes, review of medications as required. A falls corrective action form is completed post falls by the RN, which is also signed off by the GP. RN’s attended falls prevention in-service August 2013 and completed an online self-learning tool September 2013.  ii) Wound assessments are in place for six rest home wounds (two skin tears, two leg ulcers, lesion and a pressure area buttocks) and 14 wounds in the hospital (three skin tears, two graft sites, three lesions, two chronic leg ulcers, four minor wounds and one surgical site). Wound body maps are used and completed in 17 of 20 wounds. There are graphs and photographs where applicable. The RN signs each evaluation. Progress notes also detail wound healing, dressings, pain and any referrals. There is evidence of referrals to Nurse Maude complex wound care service and plastics unit. There are adequate pressure area resources such as pressure area mattresses, pressure area cushions and heel protectors.  iii) Pain assessments are available for use on admission. The effectiveness of pain relief is documented in the resident’s progress notes.  iv) There is a challenging behaviour policy that refers to the use of a challenging behaviour assessment and behaviour monitoring forms. One hospital resident with challenging behaviour is on a behaviour monitoring form. Challenging behaviour is documented in the long term care plan.  Improvements are required around pain management, use of behaviour assessment, documentation of corrective actions post falls and completion of wound assessments. |

##### 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:** |
| i) 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 documented on the accident/incident forms and post falls corrective action forms include; ultra-low beds, sensor mats, the wearing of good fitting footwear, ensuring rooms are not cluttered, use of night-lights, exercise programmes, review of medications as required. A falls corrective action form is completed post falls by the RN, which is also signed off by the GP. RN’s attended falls prevention in-service August 2013 and completed an online self-learning tool September 2013.  ii) Wound assessments are in place for six rest home wounds (two skin tears, two leg ulcers, lesion and a pressure area buttocks) and 14 wounds in the hospital (three skin tears, two graft sites, three lesions, two chronic leg ulcers, four minor wounds and one surgical site). Wound body maps are used and completed in 17 of 20 wounds. There are graphs and photographs where applicable. The RN signs each evaluation. Progress notes also detail wound healing, dressings, pain and any referrals. There is evidence of referrals to Nurse Maude complex wound care service and plastics unit. There are adequate pressure area resources such as pressure area mattresses, pressure area cushions and heel protectors.  iii) Pain assessments are available for use on admission. The effectiveness of pain relief is documented in the resident’s progress notes.  iv) There is a challenging behaviour policy that refers to the use of a challenging behaviour assessment and behaviour monitoring forms. A hospital resident with challenging behaviour is on a behaviour monitoring form. Challenging behaviour is documented in the long term care plan. |
| **Finding:** |
| i) Corrective actions documented post falls for two residents are not reflected in the long term care plan.  ii) Eight of 20 wound assessment/short term care plans are incomplete. Four wound assessments have the signature of the person carrying out the assessment, two have no description of size, three have no location on the body map and one wound assessment does not identify the type of wound. Wound assessment forms do not include medical conditions and contributing factors that could affect healing progress.  iii) a) There is no pain assessment for a rest home resident with pain on change of wound dressings. b) Management of pain and interventions for one rest home resident as identified at care plan review and physiotherapist assessment are not included in the long term care plan. c) Pain assessment for one hospital resident with on-going pain has not been reviewed three monthly. iv) There is no challenging behaviour assessment for the hospital resident on behaviour monitoring. There is no specific written evaluation around challenging behaviour. |
| **Corrective Action:** |
| i)Ensure corrective actions identified post falls are documented in the resident’s long term care plan.  ii)Ensure wound assessments are fully completed. The wound assessment form could be more comprehensive.  iii)Ensure pain assessments are completed for residents who identify pain. Ensure and needs and interventions for pain management are reflected in the resident care plan.  iv)Ensure challenging behaviour assessments are completed and reviewed for residents with challenging behaviour as per policy. |
| **Timeframe (days):** 60 *(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:** |
| The service employs a registered qualified diversional therapist (DT) for 37 hours a week to implement the activity programme for the rest home and village residents. An activity co-ordinator who is currently progressing through the national certificate in the support of the older person, works 20 hours a week providing activities for hospital level residents. Both activities persons attend relevant on site in-services and external education as available with other DT’s within the region and liaise with Active Canterbury group. They have access to internet and library resources. Both staff have current first aid certificates. The rest home, hospital and village have separate activity programmes, planned in advance. Feedback on the programme and suggestions for activities are discussed at the monthly rest home resident meetings and the two monthly hospital resident and family meetings. A resident advocate attends residents meetings. Group activities in the rest home include; exercises, word building, housie, movies, quizzes, open shop days, bowls, newspaper reading, foot spas. Activities in the hospital include; hand and nail therapy, movies, reading, short stories, exercises, quizzes, discussion groups, walks and one on one activities. Activities are provided at a time most suitable for the residents. The hospital residents join in the rest home activities as desired. Musical entertainment is provided in both areas as observed on the day of audit. A function room is available in the village for concerts. Guest speakers are invited to the home and residents participate in community activities such as arthritis day, Alzheimer’s cuppa for a cause and Waitangi day. The mobile farmyard also visits. Recently the residents chose to hold a ‘cuppa for a cause’ to raise funds for Philippine families affected by the recent tragedy. There are two lounges available for use for recreational activities in the rest home and hospital. Monthly church services, fortnightly prayer meetings and weekly communion are held in rest home and hospital. Outings are arranged for shopping trips, concerts, drives and picnics. There is a company van available and a wheelchair taxi is hired twice monthly for outings. Residents are supported to maintain community links attending church, stroke club, probus and choirs. A social history is obtained when a resident is admitted that includes interests, community links and activities of interest to the resident. A care plan is developed and reviewed six monthly. There is a multidisciplinary approach to reviews that is also consumer focused and involves the resident and/or their family as appropriate. The activity care plan is reviewed at the same time as the clinical care plan. Families receive a copy of the activity care plan. |

##### 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, RN, senior carer, DT and GP and physiotherapist. The personnel involved in the review sign the form to acknowledge their involvement. The activity care plan is reviewed at the same time as the clinical care plan. 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 rest home files and five hospital files identified that all nine long term care plans have been evaluated within the required timeframe.  D16.3c: All initial care plans of nine files sampled were evaluated by the RN within three weeks of admission. 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. |

##### 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; physiotherapy, dietitian, pain clinic, radiology, rheumatology clinic, speech language therapist, community stroke team, urology, respiratory consultant and neurologist. 20.1 Discussions with nurse manager identified that the service has access to nursing specialists such as wound, continence, and palliative care nurse, district nurses, dietitian, physiotherapist, speech language therapist, Nurse Maude 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 NM described the transfer documentation required is; Merivale transfer form, next of kin contact details , copy of advance directive, medication chart, progress notes, observations, 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:** PA Low |
| **Evidence:** |
| Medications are stored in locked medication rooms in the downstairs and upstairs rest home wings. The hospital facility has a medication room located within the nurse’s station. There is a pharmacy contract in place dated May 2013. An RN is allocated additional hours to check the four weekly medico blister packs for each area. A medication reconciliation form is used and any discrepancies are fed back to the supplying pharmacy. PRN medications are blister packed and checked weekly for usage and expiry dates. All PRN medication packs are replaced three monthly. RNs and senior caregivers undergo a comprehensive medication competency assessment that includes knowledge of policies and procedures, written competency assessment and RN supervision for at least three medication rounds. Staff attended medication education April 2013. There is a specimen signature list of medication competent persons. The Liverpool care pathway (LCP) is in place for palliative care residents. RNs have attended syringe driver training and LCP medication for the making up of syringe drivers are kept in one of the hospital controlled drugs safe. Controlled drugs stocktake is completed weekly. A pharmacy six monthly audit was last completed July 2013. All eye drops in the medication trolleys are dated on opening. Medication fridges temperatures are monitored. There is a separate specimen fridge. There are current standing orders in place. An RN and senior caregiver may record and sign for a verbal order. The GP signs off the verbal order at the next visit (sighted). There is one self-medicating resident in the rest home. A self-medication competency has been completed and reviewed by the GP at the three monthly medication reviews. Staff monitor self-medicating compliance weekly. The resident’s medication is stored safely in the bedroom (viewed). The service have three oxygen concentrators available for use.  Eighteen medication charts sampled all had photo identification (dated) and any allergies/adverse reactions noted on the medication charts. Two medication competent staff sign for the administration of controlled drugs. All prn medications charted have an indication for use. PRN medications administered have the time of administration recorded. There is evidence of GP three monthly medication reviews on 18 of 18 medication charts sampled. An improvement is required around GP signatures for the prescribing and discontinuation of medication. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Eighteen medication charts sampled all had photo identification (dated) and any allergies/adverse reactions noted on the medication charts. All prn medications charted have an indication for use. There is evidence of GP three monthly medication reviews on 18 of 18 medication charts sampled. |
| **Finding:** |
| Five of 18 medication charts did not have a GP signature for a) discontinued medications (four charts) b) newly prescribed medication (one chart) and c) one chart did not have a controlled drug discontinued that is not in use. |
| **Corrective Action:** |
| Ensure GP prescribing meets legislative prescribing requirements. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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| **Attainment and Risk:** 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 food services manager has been with the service for nine years and holds London City Guild 1 and 2 qualifications. The chef (food services manager) hours are 7.30am to 6pm. Three morning kitchen hands and two afternoon kitchen hands support the chef. Breakfast is prepared in the kitchenettes of the rest home and hospital areas. The menu is a six weekly rotation plan for summer, autumn, winter and spring seasons. The main meal is at night with a lighter lunch. The dietitian reviewed the menu November 2013. Recommendations include an increase in potato and bread and reduction in the use of cream. These recommendations are in the process of being implemented. The RN completes a nutritional assessment that is forwarded to the food services manager. Resident allergies, intolerances, type of modified diet, likes and dislikes are accommodated. Currently there are gluten intolerant, no red meat and diabetic residents catered for. Protein sandwiches and diabetic morning and afternoon teas are provided. The food services manager is notified of any resident dietary changes and weight loss. There are specialised utensils and lip plates available. Meals are delivered to the hospital building in a bain-marie and in hot boxes to the serviced apartments. Cooking and re-heating food temperatures are checked twice daily. The kitchen hands serve meals in the hospital and rest home dining rooms. Each dining room have resident dietary requirement list (not visible) to guide staff in the serving of meals. The kitchen is well equipped to cater for up to 120 meals a day. Twice daily chiller temperatures and fridge and freezer temperature are recorded. Staff are observed wearing appropriate personal protective clothing. Electrical equipment is tested and serviced. The chemical supplier conducts quality control checks on the dishwasher, monitors food safety and hygiene standards and efficiency of chemical usage. Cleaning schedules are maintained in the main kitchen. Chemicals are stored safely. Kitchen staff have attended chemical safety education May 2013. Food safety and hygiene in-service was provided October 2013. Feedback is received on the service through resident meetings, surveys and internal audits. The food services manager attends every third meeting resident meeting and weekly heads of department management meetings. |

##### 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. Infectious material is double bagged prior to disposal in the general waste. Staff interviewed are knowledgeable in the disposal of general and infectious waste. An external contractor collects the skip bin three times a week. Council bins are collected for organic waste and recycling.  Chemicals are delivered to a main locked cage that is located outside of the laundry area. The maintenance person distributes chemical supplies 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. The maintenance person is a health and safety (H&S) representative on the H&S committee. Sufficient gloves, aprons, and goggles are sighted for staff in all service areas including sluice rooms and cleaner’s room. Infection control policies state specific tasks and duties for which protective equipment is to be worn. All chemicals are stored safely throughout the facility. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The rest home beds and serviced apartments are located within a modern built two level facility. Silverdale hospital is situated in a separate building next door. The building warrant of fitness for the rest home expires 1 April 2014 and the hospital building warrant of fitness expires on 1 October 2014. Two bedrooms in the hospital building are currently being modified as a result of earthquake damage. The service employs a maintenance person 40 hours per week who has experience as a property manager and in retail hardware. The maintenance person has completed on line chemical safety course and holds a current first aid certificate. He is responsible for internal and external maintenance for both facilities and the village. Daily maintenance requests are written into the maintenance requests books in each area. Contractors carry out larger repairs and maintenance. External contractors check and maintain all fire safety equipment, service the lifts and conduct two yearly electrical checks on equipment (last in June 2013). Clinical equipment is serviced and calibrated (if required) annually. Monthly maintenance checks include (but are not limited to); call bells, pendants, van and car maintenance, and hot water temperature monitoring of resident areas. There are corrective actions documented where hot water temperatures have been outside of the recommended range. There is adequate storage for equipment such as walking frames, wheelchairs, chair scales, linen and products.  Both facilities have spacious wide corridors and handrails appropriately placed in communal areas. The outdoor areas are well maintained, safe and easily accessible for the residents. There are shaded seating areas. Two gardeners are employed to maintain all the grounds for the retirement village and rest home and hospital facilities.  Staff amenities include nurse’s stations in all clinical areas, administration offices, staff tearoom and toilet. There is a visitor toilet available.   ARC D15.3;The following equipment is available: pressure relieving mattresses, pressure area cushions, electric beds, ultra-low beds, hoists (standing and lifting) calibrated February 2013, chair and wheel on scales (last calibrated May 2013), walking frames, wheelchairs, resident transferring aids, shower chairs and sensor mats. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms in the rest home have an ensuite. All except two hospital bedrooms have an ensuite. These two rooms are located close to the communal toilet and shower. 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 caregivers 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. Six caregivers 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 (four rest home and seven hospital) are happy with their rooms. |

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

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

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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 buildings. Smaller seating areas provide an alternative area for quieter activities such as the library room. There is a computer available for residents with internet access. 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, wheelchairs or lazy boy chairs (observed). |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The laundry is spacious and has an entry and exit door with defined clean and soiled areas. There are adequate linen supplies (sighted). 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. There are plastic aprons, gloves and face shields readily accessible for laundry and cleaning staff. Cleaners are observed wearing personal protective wear while carrying out their duties. Cleaner’s trolleys were left unattended during the audit. Chemical bottles are labelled correctly with manufacturer labels. There is a spills kit in the laundry and safety data sheets. Chemicals are stored safely in the laundry. All staff have attended chemical safety courses and use of laundry equipment (March 2013). Feedback on the service is received verbally and through resident meetings. Internal audits and resident satisfaction surveys identify any areas for improvement. |

##### 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:** |
| Policies on health and safety, security, on call emergency assistance and transportation of residents address safety procedures. The New Zealand Fire Service approved the fire evacuation scheme on 8 July 2009. Fire evacuation practices are held six monthly. Training on emergency procedures was completed on 21 March 2012. Records confirm that Fire Fighting Pacific monitors all fire equipment. Appropriate fire signage and fire equipment was placed throughout the facility. Medical equipment maintenance/calibration was completed monthly by the registered nurse and annually by external companies for scales, hoists, beds, wheelchairs, oxygen cylinders and regulators.  The maintenance officer works to a maintenance schedule and is responsible for ensuring that the van has a current warrant of fitness and registration, that the oxygen cylinders are maintained in a state of readiness for use and checks of slings and hoists are completed three monthly. All current records are in place. There is always one staff on duty that is first aid trained.  In the event of an emergency, the service has two gas barbecues on site for cooking and access to five others in the neighbours. Heating can be gas fired. There is an arrangement with Hirepool for generators and other equipment.  There are 12 volt back up batteries in place for lighting, 260 litre containers of water, access to a well and two storage tanks of water on a rural property designated as being available for the service as required and extra supplies of hand towel and toilet paper are stored.  Civil defence kits are available in the hospital and rest home and hold medical and emergency supplies including torches, a radio, batteries and hand gel. A call bell system operates in all areas used by residents. This is maintained by the maintenance officer and an external contractor support any call outs. The call bell system was observed in use during the audit with staff carrying walkie talkies. All windows have security stays or other security catches. A lock up procedure is followed at night time; security lighting is in place including lighting from dusk to dawn between the hospital and rest home.  Interview with six caregivers and registered nurses confirms that they are familiar with emergency procedures. |

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

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

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

##### Criterion 1.4.7.3 (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 and ceiling heating. The communal lounges have gas log fire heating as well. Residents and families interviewed confirmed the environment is comfortable throughout the winter and summer seasons. Ventilation pumps and opening windows provide adequate ventilation throughout the facility during the summer months. Communal areas 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 policy around restraint and enablers is applicable to the type and size of the service (rest home and hospital).  The service has a restraint free philosophy.  Restraint is not used and there is currently one enabler used (lap belt for one resident in a wheelchair who is fully able to give consent).  The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. Strategies are in place to minimise the use of restraint including mobility aids and supervision of residents. Six of six caregivers interviewed confirm knowledge of restraint, enablers and management of challenging behaviours and all have completed a self-learning questionnaire around management of challenging behaviour in August 2013. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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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 programme is documented in the infection control manual.  There are clear lines of accountability for infection prevention and control that lead from all staff up to the nurse manager and to the owner/manager. Infection prevention and control is integrated into the staff, management, charge nurse and registered nurse/enrolled nurse meetings and there is an infection control meeting held two monthly. All staff interviewed aim to keep the environment and residents free from infection as described by six caregivers and registered nurses interviewed.  The programme is appropriate to the size and scope of the service.  There is a designated infection control coordinator (nurse manager) as confirmed by the nurse manager and owner/manager interviewed. A review of the programme was last completed in 2013 through the review of policies and review of the quality programme including infection control.  Staff describe taking sick leave when not able to attend work and this is as per policy. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The nurse manager provides oversight for the infection control coordinator (registered nurse).  The infection control team includes qualified health professional/s with the relevant skills, expertise and resources necessary to achieve the requirements of this standard (i.e., the nurse manager, registered nurses, owner/manager who is a GP).  The infection control coordinator has access to relevant and current information, which is appropriate to the size and complexity of the organisation, including: the internet, the Ministry of Health webpages, text books, access to experts (e.g., the DHB, Southern Community Laboratories), on-going in-service education through the DHB. The infection control coordinator can describe accessing the DHB infection control coordinator and Southern Community Laboratories for advice in November/December 2012 around an outbreak of norovirus. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D 19.2a: There are comprehensive infection control policies that supports the Infection Prevention and Control Standard SNZ HB 8134:2008. The infection control policy has been reviewed in 2013 by the owner/manager (GP) and the nurse manager. It includes all aspects of infection control e.g. infection control, chain of infection, outbreak policy, outbreak log, scabies, terms of reference, antimicrobial guidelines, decontamination, food handlers sickness policy, hand hygiene, linen management, management of staff with communicable disease, pandemic plan and policy, prophylactic antimicrobial guidelines, single use items, respiratory hygiene/cough etiquette, standard precautions, transmission based precautions, UTI, waste management and waste management flowchart.  The infection control policies link to other documentation and uses references where appropriate. |

##### 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:** |
| Infection control training is provided to staff annually at least - last provided to staff in February 2013 through a self-learning tool and workshop. Other related training is provided including wound management (May 2013), continence (July 2013) and food safety in October 2013.  On induction, all new staff are trained regarding standard precautions, hand hygiene and waste disposal.  Residents receive information around infections as per their needs. One resident has ESBL and has had training around changing the catheter and draining the catheter.  Eleven of 11 residents interviewed confirm that they receive information related to their needs and staff describe giving information in a way that they understand.  The GP confirms that staff are caring and this includes giving residents a lot of information as per their needs. The nurse manager has had training in 2012 with the DHB and staff have completed training from the Southern Community Laboratories in 2013. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance programme is outlined in policy and is determined by the infection control committee.  A monthly infection summary report is completed. The surveillance programme includes monthly analysis of infections, monthly surveillance record form, project/product consultation form and quality indicator data report completed.  Infection control data is reported to the registered nurse, charge nurse, staff, health and safety if required and quality meeting with discussion and analysis of information sighted in minutes reviewed for 2013. The surveillance of infection data assists in evaluating compliance with infection control practices and any changes lead to outcomes to improve service delivery. |

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

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

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

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

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

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