

# The Ultimate Care Group Limited - Aroha Lifecare

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Current Status: 7 January 2014

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

Aroha Lifecare provides residential care for up to 46 residents who require hospital level care, dementia level care and rest home level care. Occupancy on the day of the audit was at 46. The facility is operated by The Ultimate Care Group Limited. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provided positive feedback on the care provided.

There are three areas identified as requiring improvement during this audit relating to management of complaints, orientation of the recently appointed facility manager and developing and implementing corrective actions to address areas identified in satisfaction surveys.

## Audit Summary as at 7 January 2014

Standards have been assessed and summarised below:

### Key

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

## Consumer Rights as at 7 January 2014

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.		Some standards applicable to this service partially attained and of low risk.
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## Organisational Management as at 7 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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## Continuum of Service Delivery as at 7 January 2014

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.		Standards applicable to this service fully attained.
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## Safe and Appropriate Environment as at 7 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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## Restraint Minimisation and Safe Practice as at 7 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 7 January 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# Audit Results as at 7 January 2014

## **Consumer Rights**

Residents and family interviewed report that services are provided in a manner that respects residents' rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Residents and family interviewed state they are happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in a resident's condition. Visual inspection provides evidence that the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed, along with complaint forms.

During interviews, staff demonstrate an understanding of informed consent and informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the informed consent processes and confirm that appropriate information is provided.

The facility manager is responsible for management of complaints and a complaints register is retained. However, an improvement is required to complaints management as it is not clear that all verbal complaints are being documented in the complaints register.

## **Organisational Management**

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Aroha Lifecare. The Business Plan, Quality Improvement Plan and a Risk Management Plan reviewed include a vision statement and core values. Systems are in place for monitoring the service provided at Aroha Lifecare including regular monthly reporting by the facility manager to the Ultimate Care Group Limited head office.

A new facility manager, a registered nurse, was appointed in October 2013. Improvements are required as there is no evidence the facility manager, who is new to aged care facility management, has been orientated to their new role.

The Ultimate Care Group quality and risk management systems are imbedded at Aroha Lifecare. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. However, an improvement is required in relation to the development of corrective action plans to address shortfalls identified. There is an internal audit programme in place. Risks are identified, and there is a hazard register that identifies health & safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms and an electronic database is reviewed by personnel from The Ultimate Care Group Limited head office.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, the pharmacist, dietitian, and general practitioners is occurring. There is evidence available indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ACE education modules. Review of staff

records provide evidence that human resources processes are followed as required (eg, reference checking, criminal history vetting, interview processes for appointment and individual education records are maintained).

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three caregivers. The facility manager is on call after hours. All care staff interviewed report there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

### **Continuum of Service Delivery**

The registered nurses develop, review, update and evaluate residents' care plans at least three monthly. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept well informed. Residents and family interviewed are satisfied with the standard of care provided by staff.

There are three activities programmes for the resident groups residing in Aroha Lifecare, and some residents carry out their own activities. The diversional therapist and recreational officer provide both group and one-to-one activities. Residents interviewed report they can choose what they would like to participate in.

An appropriate medicine management system is implemented with policies and procedures clearly detailing service providers' responsibilities. Care staff responsible for medicine management have current medication competency assessments. Medication files reviewed provide evidence of documented three monthly medication reviews completed by the general practitioners. Weekly and six monthly checks of controlled drugs are completed. A visual inspection of the medication systems evidence compliance with legislation, regulations and guidelines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Review of resident meeting minutes and interviews of residents and family indicates satisfaction with the quality of the food service provided. Residents and family also confirm that adequate fluids are provided and snacks are available between meals.

### **Safe and Appropriate Environment**

Bedrooms provide single accommodation, except for one bedroom that provides double accommodation. Most of the bedrooms have wash hand basins. There is an adequate number of toilet and shower facilities throughout the facility in each area. Residents' rooms are large enough to allow for the safe use of mobility and lifting aids. There are separate lounges and dining areas in each area of the facility. Internal courtyards are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides

evidence of adequate sluice facilities, safe and hygienic storage of chemicals. cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are appropriate systems in place to ensure the physical environment is safe, and facilities are fit for their purpose.

### **Restraint Minimisation and Safe Practice**

There are currently nine residents using restraint and no residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. Restraint usage is actively minimised.

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. The residents' files reviewed demonstrate restraint assessment and risk processes are being followed and provide evidence of resident and family input into the restraint approval processes. Restraint evaluation processes are documented and implemented. Approved restraint for residents is reviewed at least monthly and as part of the care plan review. Restraint usage across the facility is monitored and reviewed and discussed at quality/staff meetings.

### **Infection Prevention and Control**

The Ultimate Care Group Limited corporate infection control management systems are fully implemented at Aroha Lifecare to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff to access.

The facility manager is the infection control co-ordinator and there is evidence they attend appropriate infection prevention and control education.

On-going infection control education has been provided for staff. The type of surveillance undertaken and reporting process is appropriate to the size and complexity of the organisation. Results of surveillance are reported on the Ultimate Care Group Limited electronic database and are collated and reported to the monthly quality/staff/infection control/health and safety meetings, and via the weekly and monthly reports' to The Ultimate Care Group. Copies of graphs of clinical indicators are displayed and staff interviewed report this information is available for them.

# HealthCERT Aged Residential Care Audit Report (version 3.91)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	The Ultimate Care Group Limited		
<b>Certificate name:</b>	The Ultimate Care Group Limited		
<b>Designated Auditing Agency:</b>	DAA Group Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Aroha Lifecare		
<b>Services audited:</b>	Medical and Geriatric Hospital. Rest Home. Rest Home Dementia		
<b>Dates of audit:</b>	<b>Start date:</b> 7 January 2014	<b>End date:</b> 8 January 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			46

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	15	<b>Hours off site</b>	10
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	15	<b>Total hours off site</b>	9
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	30	Total audit hours off site	22	Total audit hours	52
Number of residents interviewed	8	Number of staff interviewed	13	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	46	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Friday, 31 January 2014

## Executive Summary of Audit

### General Overview

Aroha Lifecare provides residential care for up to 46 residents who require hospital level care, dementia level care and rest home level care. Occupancy on the day of the audit was at 46. The facility is operated by The Ultimate Care Group Limited. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provided positive feedback on the care provided.

There are three areas identified as requiring improvement during this audit relating to management of complaints, orientation of the recently appointed facility manager and developing and implementing corrective actions to address areas identified in satisfaction surveys.

### Outcome 1.1: Consumer Rights

Residents and family interviewed report that services are provided in a manner that respects residents' rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Residents and family interviewed state they are happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in a resident's condition. Visual inspection provides evidence that the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed, along with complaint forms.

During interviews, staff demonstrate an understanding of informed consent and informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the informed consent processes and confirm that appropriate information is provided.

The facility manager is responsible for management of complaints and a complaints register is retained. However, an improvement is required to complaints management as it is not clear that all verbal complaints are being documented in the complaints register.

### Outcome 1.2: Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Aroha Lifecare. An 'Aroha Lifecare Business Plan 2014-2015', 'Quality Improvement Plan, Ultimate Care Group', and 'Risk Management Plan January 2013 - January 2014' reviewed and includes a vision statement and core values. Systems are in place for monitoring the service provided at Aroha Lifecare including regular monthly reporting by the facility manager to the Ultimate Care Group Limited head office.

A new facility manager, who is a registered nurse, was appointed in October 2013. Improvements are required as there is no evidence the facility manager, who is new to aged care facility management, has been orientated to their new role.

The Ultimate Care Group quality and risk management systems are imbedded at Aroha Lifecare. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. However, an improvement is required in relation to the development of corrective action plans to address shortfalls identified. There is an internal audit programme in place. Risks are identified, and there is a hazard register that identifies health & safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms and an electronic

database is reviewed by personnel from The Ultimate Care Group Limited head office.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, the pharmacist, dietitian, and general practitioners is occurring. There is evidence available indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ACE education modules. Review of staff records provide evidence that human resources processes are followed as required (eg, reference checking, criminal history vetting, interview processes for appointment and individual education records are maintained).

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three caregivers. The facility manager is on call after hours. All care staff interviewed report there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

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

The registered nurses develop, review, update and evaluate residents' care plans at least three monthly. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept well informed. Residents and family interviewed are satisfied with the standard of care provided by staff.

There are three activities programmes for the resident groups residing in Aroha Lifecare, and some residents carry out their own activities. The diversional therapist and recreational officer provide both group and one-to-one activities. Residents interviewed report they can choose what they would like to participate in.

An appropriate medicine management system is implemented with policies and procedures clearly detailing service providers' responsibilities. Care staff responsible for medicine management have current medication competency assessments. Medication files reviewed provide evidence of documented three monthly medication reviews completed by the general practitioners. Weekly and six monthly checks of controlled drugs are completed. A visual inspection of the medication systems evidence compliance with legislation, regulations and guidelines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Review of resident meeting minutes and interviews of residents and family indicates satisfaction with the quality of the food service provided. Residents and family also confirm that adequate fluids are provided and snacks are available between meals.

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

Bedrooms provide single accommodation, except for one bedroom that provides double accommodation. Most of the bedrooms have wash hand basins. There is an adequate number of toilet and shower facilities throughout the facility in each area. Residents' rooms are large enough to allow for the safe use of mobility and lifting aids. There are separate lounges and dining areas in each area of the facility. Internal courtyards are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are appropriate systems in place to ensure the physical environment is safe, and facilities are fit for their purpose.

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

There are currently nine residents using restraint and no residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. Restraint usage is actively minimised.

Systems are in place to ensure assessment of residents is undertaken prior to restraint usage being implemented. The residents' files reviewed demonstrate restraint assessment and risk processes are being followed and provide evidence of resident and family input into the restraint approval processes. Restraint evaluation processes are documented and implemented. Approved restraint for residents is reviewed at least monthly and as part of the care plan review. Restraint usage across the facility is monitored and reviewed and discussed at quality/staff meetings.

### **Outcome 3: Infection Prevention and Control**

The Ultimate Care Group Limited corporate infection control management systems are fully implemented at Aroha Lifecare to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff to access.

The facility manager is the infection control co-ordinator and there is evidence they attend appropriate infection prevention and control education. On-going infection control education has been provided for staff. The type of surveillance undertaken and reporting process is appropriate to the size and complexity of the organisation. Results of surveillance are reported on the Ultimate Care Group Limited electronic database and are collated and reported to the monthly quality/staff/infection control/health and safety meetings, and via the weekly and monthly reports' to The Ultimate Care Group. Copies of graphs of clinical indicators are displayed and staff interviewed report this information is available for them.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	47	0	2	1	0	0
<b>Criteria</b>	0	98	0	1	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0	0	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	The relative of a resident is interviewed and reports they have made a verbal complaint concerning missing items of new clothing and they have not been provided with any feedback as to the progress of the complaint investigation. Review of the complaints register indicates this complaint has not been recorded in the complaints register.	Provide documented evidence that all complaints received (verbal and written) are entered in to the complaints register and that complainants are provided with progress reports and outcomes of investigations	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	There is no documented evidence available to indicate that the facility manager has been orientated to the position of facility manager.	Provide documented evidence that the facility manager has been orientated to the role of facility manager, including Ultimate Care Group's system	90
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	There is no evidence that corrective action plans have been developed and implemented to address the areas identified as requiring improvement in the family and residents satisfaction surveys completed in September 2013.	Provide documented evidence that corrective action plans are developed and implemented to address areas identified as requiring improvement in the residents and family satisfaction surveys.	180

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Nine of nine care staff (five caregivers - covering morning, and afternoon shifts; two registered nurses - working morning shifts, and one enrolled nurse working morning shifts), demonstrate a knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. All care staff interviewed confirm they have received recent education on the Code as part of their in-service education programme. Review of education records and staff files (seven) evidences education provided on the 14 May 2013.

Visual observations during the audit indicates staff are respectful of residents and incorporate the principals of the Code in their practice. Staff are observed knocking before entering residents' bedrooms.

Residents interviewed (three rest home and four hospital) and four family members (one hospital resident and three residents with dementia) confirm that staff respect their rights and most are aware of the Code. The one dementia resident was unable to respond.

Copies of the Code is observed at the entrances and throughout the facility. All residents are provided with an information pack on admission and this includes information on the Code.

The ARC requirements are met.

### 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.

**Attainment and Risk:** FA

**Evidence:**

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

**Standard 1.1.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Resident meetings are held monthly and minutes reviewed indicates feedback from residents on various aspects of service delivery, including the residents making suggestions concerning meals, laundry and the activities programme. Residents and family interviewed report they are informed of their rights by both pre-admission and admission information being provided. All residents are provided with an information pack on admission and this includes information on the Code and complaints processes. The Code - including large print posters - and advocacy details are displayed throughout the facility, and copies are available and accessible and residents and family are given opportunity for discussion regarding these. The admission agreement is reviewed and includes information on the Code of Residents' Rights. Seven of seven residents' files reviewed have signed admission agreements. During this audit staff are observed discussing the Code with a family who were making enquiries regarding a placement for their relative.  The ARC requirements are met.

**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.

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Residents and family interviewed confirm they or their relative is receiving services appropriate to their needs and that staff treat them with respect and dignity. Residents confirm they have a choice of what to do with their day and have a right to refuse if they do not want to participate. Residents and family also confirm their and their relative's privacy is respected and they are able to be as independent as they desire/are able. Residents confirm they wear their own clothing and they have appropriate storage facilities in their rooms. They also confirm that their rights are respected, including any spiritual and cultural needs.</p> <p>Visual inspection of the facility provides evidence that apart from one bedroom, all bedrooms are single, and residents have dedicated areas to keep their personal property and possessions and the rooms are as personalised as residents want them to be. The facility has areas available where residents are able to meet with family members if required. There is a suitable environment available for caring for a dying resident and their family. Communal hygiene facilities display appropriate signage and a safe locking system.</p> <p>Residents' files reviewed demonstrates residents' access to the spiritual and cultural care of their choice is recorded in the resident's admission documentation, which details spiritual affiliations and cultural aspects of care, and in the registered nurse (RN) assessment in the care plans that identifies spiritual and cultural needs. Church services are held monthly by a Chaplin who also provides support for residents as needed.</p> <p>The admission agreement reviewed and includes information on the residents' responsibility for safety, security and insurance cover of their personal belongings. Care staff interviewed confirm residents' physical, visual, auditory and personal privacy is being maintained and they respect residents' spiritual and cultural needs. Care</p>

staff also confirm education on the Code of Rights and this finding confirmed during review of 2013 in-service education programme and staff education records. Appropriate policies and procedures are in place including policies to guide service providers acting on advance directives and maximising independence when they are caring for people where this is likely to be an issue. Policies and procedures are also reviewed for cultural safety, spirituality, death and dying, and abuse and neglect. Residents, family and staff state they have not witnessed any abuse or neglect. The ARC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Documentation reviewed includes appropriate Māori protocols, and a Māori health plan. There are currently three residents who identify as Māori.

Access to Māori support and advocacy services is available via Te Whare Rapuora, Maori Wardens.

Systems are in place to allow for review processes including input from whanau/family, where appropriate, for any resident who identifies as Māori. Cultural assessments are part of all residents' care plans and are sighted in residents' files. The file of one resident who identifies as Māori is reviewed and indicates their family is involved in this resident's care.

Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. There are three staff members who identify as Māori, and one staff member speaks Te Reo Maori. Cultural awareness education included a cultural day put on by staff where they dressed in their national costumes and provided traditional food. Staff report they and the residents enjoyed the day.

Signage on all communal bathroom facilities are in both Māori and English.

The ARC requirements are met.

#### **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.

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

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

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

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

**Corrective Action:**

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

**Criterion 1.1.4.5 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are different ethnic groups within the facility and observation during this audit indicates the individual's cultural values and beliefs are being met. Service providers documentation provides evidence appropriate culturally safe practices are implemented and are being maintained. Policies list access details to appropriate expertise (eg, cultural specialists, and interpreters).

Residents' files reviewed demonstrate that admission documentation identifies ethnicity, cultural and spiritual requirements and family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process.

Residents and family interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. Church services are held on site as part of the activities programme.

There are a number of care staff from different cultures working at Aroha, and care staff interviewed confirm a very sound understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.

The ARC requirements are met.

**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.

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

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

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

ARHSS D16.5e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and staff codes of conduct. Policies and procedures which address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) are reviewed and met requirements. Expected staff practice is outlined in job descriptions held on files. Job descriptions and employment contracts detail responsibilities and boundaries.</p> <p>Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to.</p>

### 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.

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

### Standard 1.1.8: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Systems are in place to ensure service providers receive a range of opportunities which promote good practice within the facility. The service provider's documentation evidences that policies and procedures are based on evidence-based rationales. Education by specialist educators is provided as part of the in-service education programme and this was confirmed during review of education records and interview of the business manager (BM) who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The senior RN reports they practice the Liverpool Care Pathway, and refer to specialists, such as the wound nurse specialist. The ARC requirements are met.

### 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.

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

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Open disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed (one rest home, two dementia and four hospital) provides evidence that communication with family is being documented in residents' records in the 'Family/Whanau Communication Record'. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in an incident/accident register in the individual resident's file. Meetings with family are held if there are concerns (minutes sighted in residents' files). Emails are sent or families phoned who live outside the area or overseas and families are contacted following the three monthly reviews of care.

Residents and family interviewed confirm that staff communicate well with them. Family interviewed report they are kept very well informed, apart from the one family member who has not received feedback following making a complaint (refer 1.1.13). Residents interviewed confirm they are aware of the staff that are responsible for their care. The senior RN advises access to interpreter services is available if required via the DHB and interpreter services, and there are staff who speak different languages including Te Reo Maori.

The ARC requirements are met.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The senior RN advises informed consent is discussed and recorded on the resident's admission to the facility.</p> <p>Residents and family are provided with various consent forms on admission for completion as appropriate, including advance directives. The three tracer residents have advance directives signed by the GP stating these resident are not competent to make informed decisions. Resident files reviewed have copies of enduring power of attorney (EPOA) documents where EPOAs are recorded. A 'Checklist For Enduring Power of Attorney' is sighted on residents' files and includes information on whether or not there is a named EPOA and if a copy of this documentation has been obtained.</p> <p>Staff interviewed (five caregivers, two RNs, one EN) demonstrate a good understanding of informed consent processes. Residents and family interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.</p> <p>Residents' files (one rest home, two dementia and four hospital) reviewed demonstrate written and verbal discussions on informed consent has occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights (confirmed by staff interviews).</p>

The ARC requirements are met.

**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.

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has appropriate policies regarding advocacy/support services that specify advocacy processes and how to access independent advocates. The diversional therapist advises a Chaplin visits and acts as an advocate and offers support to residents.</p> <p>Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they have had education on the Code of Right, advocacy, and complaint management as part of their education programme. This was confirmed during review of staff education records.</p> <p>Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the Health and Disability Advocate details are displayed along with advocacy information brochures. The admission pack is reviewed and provides evidence advocacy, complaints and the Code of Rights is included.</p> <p>The ARC requirements are met.</p>

**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.

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

**Standard 1.1.12: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by the visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs and the news via, for example, reading of the newspaper each day.</p> <p>Residents interviewed confirm they can have access to visitors of their choice and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a new mobility van is available to take residents on community visits. Residents' files reviewed demonstrate that activity plans identify support/interest groups. This includes going out to the library and 'Cross Roads' for socialising and activities.</p> <p>The ARC requirements are met.</p>

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

Consumers have access to visitors of their choice.

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

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

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

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

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

**Standard 1.1.13: 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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>An area requiring improvement has been identified with complaints management as it is not clear that all verbal complaints are being documented in the complaints register (see criterion 1.1.13.3). A complaints register is maintained at the facility and there are eight complaints recorded for 2013. The last complaint documented is dated 13 August 2013. A complaints register is also maintained at The Ultimate Care Group (UCG) head office for complaints that are escalated up to them (not reviewed during this audit). Reporting of complaints occurs via monthly meetings and via the managers' reports to the UCG head office. The business manager reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. The business manager advises the complaint that was being investigated during the last audit in January 2012 by the local District Health Board (DHB) has been resolved.</p> <p>Documented complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents</p>

and their families as part of the admission process. Residents (four hospital, three rest home) and family members (three dementia and one hospital) interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of residents ability to raise any issues they have, and this was confirmed during interviews of residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality/staff meeting minutes and manager's monthly reports evidences reporting of complaints.

Not all of the ARC requirements are met.

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

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

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The complaints register is reviewed and there are eight complaints recorded for 2013. The last complaint documented is dated 13 August 2013. Printouts of Ultimate Care Group (UCG) electronic database used for documenting adverse events, including complaints is reviewed. The relative of a resident is interviewed and reports they have made a verbal complaint concerning missing items of new clothing and they have not been provided with any feedback as to the progress of the complaint investigation. Review of the complaints register indicates this complaint has not been recorded in the complaints register.
<b>Finding:</b> The relative of a resident is interviewed and reports they have made a verbal complaint concerning missing items of new clothing and they have not been provided with any feedback as to the progress of the complaint investigation. Review of the complaints register indicates this complaint has not been recorded in the complaints register.

**Corrective Action:**

Provide documented evidence that all complaints received (verbal and written) are entered in to the complaints register and that complainants are provided with progress reports and outcomes of investigations

**Timeframe (days):** 90 (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

**Attainment and Risk:** PA Moderate

**Evidence:**

An area requiring improvement relating to orientation of the recently appointed facility manager has been identified during this audit (see criterion 1.2.1.3.).

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Aroha Lifecare. An 'Aroha Lifecare Business Plan 2014-2015', 'Quality Improvement Plan, Ultimate care Group', and 'Risk Management Plan January 2013 - January 2014' is reviewed and includes a vision statement and core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed were documented values, mission statement and philosophy, which are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

UCG has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. Interview of the Manager Audit and Compliance from UCG Head Office confirms reporting processes and monitoring of quality and risk management goals.

There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and this group is responsible for reviewing clinical issues and policies and procedures following feedback from each of the 16 UCG sites. Each of the four CSMs is responsible for liaising with four or five UCG sites to ensure their participation in the process. 'Ultimate Care Group Clinical Governance Group Terms of Reference' are reviewed.

Meeting schedules and minutes are reviewed of monthly quality/staff meetings held and two monthly resident meetings. Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and benchmarking data.

A new facility manager (FM) has been appointed in October 2013 and is not present during this audit for interview. The FM is new to facility management but has worked in the aged care sector as a clinical co-ordinator for 12 months prior to their appointment as FM at Aroha Lifecare. During interview the

business manager advises there have been four new facility managers since April 2012 at the date of audit, and four temporary managers from other UCG facilities during this time. Staff interviewed report they have found this lack of stability and constant change of leadership 'unsettling'.

The FM provides weekly and monthly reports to the governing body and these are reviewed during this audit. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

Review of the facility manager's and business manager's (BM) personal files and interview of the BM indicates the managers undertake training in relevant areas. Twenty four hour registered nurse (RN) cover is provided and the FM and a senior RN, in the absence of the FM, is responsible for oversight of clinical care provided to residents. The senior RN is interviewed during this audit and confirms their responsibility in the absence of the FM. The senior RN's personal file is reviewed. Support for the FM and BM is provided by a Regional Operations Managers for UCG.

Aroha Lifecare is certified to provide hospital level care, rest home level care and dementia level care. There are 46 beds provided, 14 of which are in a secure dementia unit. Twenty nine of the remaining 32 beds are able to be used for either rest home or hospital use. On day one of this audit there are 26 hospital residents, six rest home residents and 14 dementia residents. Ultimate Care Group Limited have contracts with the DHB to provide aged related residential care (rest home, dementia and hospital services), long term chronic care and respite and day care.

Not all of the ARC requirements are met.

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

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

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

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

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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> The facility manager (FM) was not present during this audit and was not able to be interviewed. The FM's personal file is held off site at Ultimate Care Group (UCG) head office and is not able to be reviewed. The FM's curriculum vitae (CV), training records, practising certificate and job description are reviewed. Review of the FM's CV indicates they were appointed to this role on 29 October 2013 and have previous aged care experience. Interview of the Audit and Compliance manager and Business Manager (BM) indicates the FM spent two weeks with the Acting FM as part of their orientation. Review of the FM's CV indicates this is the first time they have been appointed to a facility management position. A blank orientation form is reviewed during this audit.
<b>Finding:</b> There is no documented evidence available to indicate that the facility manager has been orientated to the position of facility manager.
<b>Corrective Action:</b> Provide documented evidence that the facility manager has been orientated to the role of facility manager, including Ultimate Care Group's system
<b>Timeframe (days):</b> 90 (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are appropriate systems in place to ensure the day-to-day operations of the service continues should the facility manager (FM) be absent. A senior registered nurse (RN) fills in for the FM if they are absent and is interviewed during this audit (see 1.2.1). Twenty four hour RN cover is provided. There is also a business manager (BM) who is responsible for non-clinical support who reports to the FM.  An UCG Regional Operations Manager, and other personnel from UCG Head Office are also available for assistance and support as required. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the FM, senior RN and business manager (BM) confirms their responsibility and authority for their roles.  The requirements of the ARC are met.

### 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.

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

### Standard 1.2.3: 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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>An area requiring improvement is identified relating to completion of corrective action plans. Areas are identified as requiring improvement in the family and residents satisfaction surveys completed in September 2013 via UCG head office (see criterion 1.2.3.8). Collated results are reviewed and indicate the majority of responders are either satisfied or very satisfied with the various aspects of service provided.</p> <p>The Ultimate Care Group (UCG) 'Quality and Risk Management Plan - 2012 - 2014' is used to guide the quality programme and includes quality goals and objectives. The Ultimate Care Group (UCG) quality and risk management systems are imbedded at Aroha Lifecare. Aroha Lifecare has an established, documented, and maintained quality and risk management system. UCG launched 'Releasing Time to Care' (RTTC) modules at some trial sites in January 2012 and rolled it out to all UCG sites in August 2012. Aroha Lifecare have integrated elements the RTTC modules in to their service.</p> <p>There is an internal audit programme in place and completed internal audits for 2013 are reviewed. Review of quality improvement data provides evidence the data is being reported to Ultimate Care Group Head Office via their intranet as well as to staff through various meetings. Combined quality improvement / staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Resident meetings are also held two monthly.</p> <p>UCG implemented an electronic database (Inscribe database) in December 2012 which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. Information on this database, including benchmarking graphs, are reviewed.</p> <p>Clinical indicators are recorded on various registers and forms and are reviewed during this audit. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly</p>

quality/staff meetings.

Internal audits (with the exception of family and resident satisfaction survey reported in 1.2.3.8), accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that require/s improvement. There is documented evidence available indicating that issues identified as requiring follow through at meetings are discussed at subsequent meetings (eg, quality/staff and residents' meetings).

Staff interviewed report they are kept informed of quality and risk management issues, including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office in each wing.

The FM is responsible for providing a 'Weekly and Monthly Report' to UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, Resident 'Ins and Outs', Property/Environmental Issues, Financial, General Comments, Compliance/Indicator Summary.

Quarterly internal audits are being undertaken by the Manager Audit and Compliance from the Ultimate Care Group to ensure compliance with the quality and risk management programme, certification requirements, and funding contract requirements. Corrective action plans are developed following these internal audits to address any improvements required and the facility is re-audited if required to achieve compliance with the standards set by the organisation. The outcome of these audits are reported to the Board.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The CAG from UCG is responsible for reviewing policies and procedures. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

A Health & Safety Manual is available that includes relevant policies and procedures. Risks are identified, and there is a hazard register that identifies health & safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and reviewed and all biomedical equipment has appropriate performance verified stickers in place.

Not all of the requirements of the ARC are met.

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

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

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

**Corrective Action:**

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

**Criterion 1.2.3.3 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.3.4 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

**Criterion 1.2.3.8 (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.

**Attainment and Risk:** PA Low

**Evidence:**

Resident and relative satisfaction surveys have been completed in September 2013 and there are areas requiring improvement identified in these surveys. Quality and staff meeting minutes for the meeting held on 17 December 2013 indicates the outcome from these surveys were discussed at this meeting but there are no corrective actions documented to address the improvements required.

Corrective actions required are documented in various meeting minutes and forms reviewed during this audit.

**Finding:**

There is no evidence that corrective action plans have been developed and implemented to address the areas identified as requiring improvement in the family and residents satisfaction surveys completed in September 2013.

**Corrective Action:**

Provide documented evidence that corrective action plans are developed and implemented to address areas identified as requiring improvement in the residents and family satisfaction surveys.

**Timeframe (days):** 180 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.2.4: 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

**Attainment and Risk:** FA

**Evidence:**

The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe electronic database, and filed in residents' files. 2013 and early 2014 data reviewed includes summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events. An 'Incident Management Form' is used to document all incidents that are referred to UCG head office.

There is an open disclosure policy. Residents' files reviewed (four hospital, two dementia and one rest home) provide evidence of communication with families following adverse events involving the resident, or any change in a resident's condition. Family members interviewed (four) confirm they are made aware of any adverse events (as appropriate) and of changes in their relatives condition in a timely manner.

Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).

ARC requirements are met.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.4.3 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Standard 1.2.7: 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

**Attainment and Risk:** FA

**Evidence:**

Written policies and procedures in relation to human resources management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (seven of seven) along with employment agreements, criminal record vetting, completed orientations and competency assessments.

The FM is responsible for management of the inservice education programme and the programme is developed in conjunction with the BM. There is evidence available indicating inservice education is provided for staff at least one a month. This education is supplemented with e-learning via an external agency that has developed 21 learning modules that are specific to the aged-care sector. Aroha Lifecare has been providing this learning for the last two years and the BM advises a different module is selected each month and staff are required to complete and return the learning material for each module by the end of each month.

Individual records of education are maintained for each staff member and copies are reviewed on staff files. Also viewed are competency assessment and

education spread sheets as well as education records for each session, and inservice education programmes.

An enrolled nurse working in the dementia unit is the new (December 2013) Health Education Trust ACE assessor for the facility. All caregivers are required to complete the ACE modules. Thirteen care staff work in the dementia unit and nine have completed the dementia specific modules; one has submitted their documentation to Health Education Trust for review; and three are new appointments (within the last six months) and have not yet enrolled to complete the dementia modules. It is UCG policy that all RNs are required to complete the ACE Dementia education modules.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' for at least three days at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (ie, the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy).

An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Registered nurses (RN's) complete the professional development and recognition programme (PDRP) via the local DHB and evidence of this is reviewed on three of the four RN files reviewed. The fourth RN is a new appointment and has not commenced the PDRP programme yet. Annual practising certificates are current for all staff who require them to practice.

Care staff interviewed (five caregivers, two RNs and one EN) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals. ARC requirements are met.

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

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a clearly documented rationale ('Policy For Service Management') for determining service provider levels and skill mixes in order to provide safe service delivery in place at Aroha Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. 'The Ultimate Care Group Rostering Tool' is used by the facility manager to report to UCG head office on a weekly basis. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three caregivers (one each in the hospital area, one in the dementia unit and one in the rest home area). The facility manager is on call after hours.

Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is generally enough staff on duty to provide them with adequate care.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident information is entered in an accurate and timely manner into a register (electronic) that is appropriate to the service and is in line with the requirements of NZHIS. Interview of the administrator confirms resident's data is entered on the day of admission to the facility. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed.

A visual inspection of the facility evidences that residents' information is stored in the staff areas and is held securely and is not on public display. Clinical notes are current and accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier. Resident documentation indicates staff record their name and designation and staff sign each entry in resident documentation.

Seven of seven clinical staff interviewed (two RNs, one EN and five caregivers) confirm they know how to maintain confidentiality of resident information. Historical records are held on site for 12 months and are then transferred to Recall for storage.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

**Corrective Action:**

**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

**Attainment and Risk:** FA

**Evidence:**

Documented systems and processes are implemented to ensure residents' entry into the service has been facilitated in a competent, equitable, timely and respectful manner. The service's philosophy is recorded and communicated to residents, family, relevant agencies and staff and displayed at the facility. The admission agreement defines scope of service and includes all contractual requirements (sighted). Residents' admission agreements evidence residents', family or EPOA 'sign off'. The senior RN interviewed confirms access and entry processes are followed. This facility operates 24 hours a day seven days a week (24/7). The service provides information to potential referral sources. Resident information is sighted with all relevant information for the resident and family recorded. Residents' files reviewed demonstrate all needs assessments are completed for appropriate levels of care. Resident and family interviews confirm their input into the admission process.

Residents are assessed by a Needs Assessment and Service Co-ordination (NASC) agency prior to entry as being suitable for rest home, dementia or hospital level care.

Admission agreement reviewed and meets the requirements of ARC Clause D 13. (k). ARC requirements are met.

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.2: 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

**Attainment and Risk:** FA

**Evidence:**

Decline of resident entry to the service is documented and the resident, and/or their family and agency are informed of the reason for this. The scope of the service provided by the organisation is identified and communicated to all concerned. Staff report residents will be declined entry if not within the scope of the service or if a bed is not available at the time and referral is made back to the NASC service.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.3: 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; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

#### Attainment and Risk: FA

##### Evidence:

Seven resident files reviewed (four hospital, two dementia and one rest home) including three residents files using tracer methodology, provide evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident or family input and the service is co-ordinated to promote continuity of service delivery. Seven of seven clinical staff interviews confirm residents or family members are involved in all stages of service provision. Apart from the one dementia resident, residents and family confirm their input into the development of residents' care plans. Six residents' files reviewed demonstrate that care plans are developed by the RNs, and one resident's care plan is developed by the EN and counter signed by a RN. Care plans are comprehensive and interventions detailed to guide staff. Care plans are signed off by the resident or family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Risk assessments are completed on admission and at least three monthly and include Norton scale for pressure areas, Coombes assessment, pain, oral mental score test, and nutritional assessment. Family communication records are maintained as sighted in all seven residents' files. There is a process to identify and respond to variances/trends (e.g. accident / incident / unwanted events reporting system). An 'Incident Notification to Families' form documents the timeframes when family wishes to be notified according to whether Incidents/Accidents are falls without injury, minor injury or minor skin tears. Documentation reviewed provides good evidence that skin integrity monitoring, the management of wounds, and falls with injury are managed well. Multidisciplinary reviews of care are completed six monthly. GP notes reviewed show three monthly reviews and all residents have a GP exemption for monthly reviews signed by the GP.

Handover between the morning and afternoon shifts was observed on the first day of the audit in the hospital area, where the morning shift RN handover to the afternoon shift RNs and care staff. The handovers are comprehensive and are both written and verbal. The GP who has the majority of residents is interviewed on site and reports that in their opinion, the care provided to residents is very good, and that this is partly due to strong leadership provided by the senior RN. Interview of the senior RN also provides evidence of their attention to detail and in-depth knowledge of all the residents residing in Aroha Home & Hospital.

Competency assessments are current for all staff that are responsible for the management of medicines. Clinical staff have current restraint competency assessments. All staff in contact with residents have received on-going education in challenging behaviour. ARC requirements are met.

##### Tracer – Dementia Care

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

##### Tracer - Hospital

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

##### Tracer- Rest Home

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner as confirmed for all residents' files reviewed. There are processes in place to seek information from a range of sources, for example, family, GP, specialists and referrer. Policies and protocols are in place to ensure co-operation between service providers and to promote continuity of service delivery. Residents' files reviewed provides evidence residents' discharge/transfer information from DHB or other health provider is available and appropriate resources and equipment are available. The senior RN interviewed confirms that assessments are conducted in a safe and appropriate setting including visits from the GP. All residents interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care. Seven of seven residents' files evidence risk assessments on admission are conducted and recorded, and risk assessments are completed at least three monthly, in line with the care plans. These include Norton scale for pressure areas, Coombes assessment, pain, oral mental score test, and a nutritional assessment. A resident with dementia also has a mood, sadness and depression assessment, and challenging behaviour assessment.  ARC requirements are met.

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

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

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

**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

**Attainment and Risk:** FA

**Evidence:**

The seven residents' files (including the tracer residents) reviewed provide evidence residents' care plans are individualised and integrated. The long-term goals are identified by the residents, family and staff and reviewed at regular intervals, at least three monthly or as needs change. Residents and family have input into their care planning, as confirmed at resident and family interviews. Staff interviewed report that care plans are accurate and up to date. Resident's files reviewed provide evidence the clinical care/treatment/support or interventions that are to be provided by the staff are current, and provide very good guidance for staff.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Documentation and observations made of the provision of services and interventions demonstrate that consultation and liaison is occurring with other services, this includes a range of nurse specialists from the DHB. Seven of seven residents' files (including the three resident tracers) reviewed provide evidence care plans record appropriate interventions that are comprehensive and provide good detail and are based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement. Residents and family interviewed confirm their or their relative's current care and treatments meet their needs. Family/Whanau communication sheets and progress notes record family communications as sighted in all seven residents' files reviewed. Residents in the dementia unit all have '24 Hour Clocks' on their file that describes interventions/diversional activities for the 24 hour period.  ARC requirements are met.

**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.

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are three activity programmes for the three resident groups residing in Aroha Home & Hospital that supports their interests, needs and strengths. A diversional therapist and a recreational officer job share and provide activities seven days per week. Care staff are also responsible for providing activities for residents in the dementia unit. Group and one to one activities are provided and all resident join together for entertainment. Residents interviewed confirm they enjoy the activities provided. They report they can choose what they would like to participate in. Seven of seven resident files reviewed have completed resident profiles and activities are part of the care plan. The diversional therapist is interviewed and reports the van outings are very popular and this is sighted on the planned activity programme.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Seven of seven residents' files reviewed (including the three tracer residents) provide evidence that evaluations of care plans are within stated timeframes and at least three monthly. Evaluations are conducted by the RNs with input from the resident, family, care staff, and diversional therapist/recreational officer. Family are notified of any changes in a resident's condition, as evidenced in residents' files reviewed. Resident interviews confirm their participation in care plan evaluations. Input from specialists includes - wound specialist nurse, speech language specialist, palliative care specialist from the local hospice, infection control specialist, and dietitian. Residents' files evidence referral letters to specialists and other health professionals. Short term care plans are in place on residents' files for short term changes in condition, and care plans are updated to reflect changes.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Residents' files reviewed provide evidence completed referral forms / letters to demonstrate resident referral to and from other services. Residents' files reviewed provide evidence family communication sheets and progress notes document family involvement and facility communication with them, as appropriate. Interviews with staff confirm referrals are made to other health professionals as appropriate.</p> <p>ARC requirements are met.</p>

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

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

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Residents' files reviewed provide evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files. Interviews with staff confirm transfers and discharge is co-ordinated and copies of documents are provided.  
ARC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Medicines are dispensed and delivered by the pharmacy using the Robotic system. Each medicine prescribed is signed by the GP. Each resident has an individual medicines profile and medicine prescription form, and medicine signing sheets. The GPs complete a medicine reconciliation on admission for residents. A controlled drug register is maintained and evidences weekly and six monthly checks. Bulk medicines are held for a small amount of controlled drugs. Medicines requiring refrigeration are stored in a dedicated fridge, in the medication room. The temperatures are recorded on a daily basis and are within the recommended range for

medicines.

Medicine reviews by the GPs are recorded in the medicine charts at least three monthly as confirmed in 14 of 14 medicine files reviewed (including the three tracer residents). There is evidence staff are signing off as the dose is administered. This is observed during a medication round.

RNs, the EN and senior caregivers are responsible for medicine management, and have received education, and have current medicine completed. The medication round was observed at lunch time where medicines were observed to be managed safely. The medicines policy includes a section on the self-administration of medicines; currently there are no residents self-administering their own medicine. The GP reports the management of medicines is managed very well, and the GP has no concerns.

Medication audit is completed on 29 November 2013 and a pharmacy audit was conducted on the 17 December. Report reviewed and congratulates Aroha staff for their safe management of medicines. Medicine management complies with current legislative requirements and safe practice guidelines. ARC requirements are met.

#### **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.

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

#### **Criterion 1.3.12.3 (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.

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

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Menus are four weekly, and are planned and reviewed by a dietitian annually.

Residents confirm that adequate fluids are provided and snacks are available between meals (e.g. Fruit, bread, sandwich fillings, biscuits, cake, and supplements).

Residents' files reviewed (four hospital, two dementia and one rest home) demonstrate regular monthly weighing and monitoring of individual resident's weight and nutritional needs. Dietary profile sheets are completed on admission and copies of these are held in a folder in the kitchen and reviewed during this audit. Residents care plans identify nutritional needs and interventions are documented.

Residents are referred to the dietitian when required with input from their GP, if they experience unintentional weight loss. Referrals are also made to a speech language therapist if required.

Visual inspection of the kitchen and food areas evidences the areas are maintained and cleaned to an adequate standard, and fridge and freezer and food temperatures are monitored daily. Interview with the cook confirms kitchen staff have received education on food safety and chemical safety. Emergency food and water supply is stored at the facility. Interview with the cook confirms good knowledge of individual resident's likes and dislikes and special diets. Kitchen and food handling audits are completed on the 18 November 2013.

ARC requirements are met.

#### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

**Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and are accessible for staff. Hazard Register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in December 2013. Monthly visits are made by Ecolab representative who reviews kitchen, cleaning and laundry processes. Copies of these reports are reviewed during this audit.

A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks viewed in sluice room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Sluice room is available for the disposal of waste and hazardous substances.

ARC requirements are met.

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.</p> <p>A maintenance person is employed for 30 hours a week and is interviewed during this audit. During interview the maintenance person confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance verified stickers in place on medical equipment. Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 30 April 2014.</p> <p>A visual Inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to an adequate standard.</p> <p>Corridors allow residents to pass each other safely; safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (eg, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).</p> <p>Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.</p>

Residents and family interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents and family interviewed confirm they and their relative are able to move freely around the facility and that the accommodation meets their needs.

ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Apart from one double bedroom, all other bedrooms provide single accommodation and most have wash hand basins. There is an adequate number of toilet and shower facilities available throughout the facility.</p> <p>Visual inspection provides evidence that toilet, shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).</p> <p>All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant and signage is bilingual (Maori and English). Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence. The ARC requirement is met.</p>

**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.

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

**Standard 1.4.4: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  Visual inspection provides evidence that adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff, residents and family. The majority of the bedrooms have double leaf doors and are large enough to allow for easy access for mobility aids.  The ARC requirements are met.

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

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

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

**Corrective Action:**

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

### **Standard 1.4.5: 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

**Attainment and Risk:** FA

**Evidence:**

Visual inspection provides evidence that adequate access is provided to lounges and dining rooms in each area. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

The ARC requirement is met.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.4.6: 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

**Attainment and Risk:** FA

**Evidence:**

Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons. All linen is washed on site in the laundry and there is adequate dirty / clean flow. Care staff are responsible for doing the laundry and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.

Visual Inspection evidences the implementation of cleaning and laundry processes. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning reviewed, along with monthly Ecolab reports.

Visual inspection of the facility evidences: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste (i.e. sluice room; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas).

Residents and family interviewed state they are satisfied with the cleaning and laundry service, with one family member stating there are times when personal laundry gets mixed up, but that this is usually sorted out by staff.

ARC requirements are met.

### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.4.6.3 (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.

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

### Standard 1.4.7: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.</p> <p>New Zealand Fire Service letter dated 15 May 2003 sighted advising evacuation scheme approval. The last trial evacuation was held on 12 November 2013. All registered nurses and personnel who drive the van with residents in it are required to complete first aid training. All staff are required to complete CPR training. There is at least one designated staff members trained on each shift with appropriate first aid training.</p> <p>Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled evidences current training regarding fire, emergency and security education.</p> <p>Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.</p> <p>A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.</p> <p>A visual inspection of the facility evidences emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones.</p>

There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner.

ARC requirements are met.

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents interviewed confirm the facilities are maintained at an appropriate temperature.

ARC requirement is met.

### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are currently nine residents using restraint and no residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. The senior RN states they are actively reducing restraint use, and have introduced low beds, concave mattresses, and landing mattresses. Restraint usage has decreased by three since the last audit.</p> <p>ARC requirement is met.</p>

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

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

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

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

Consumers receive services in a safe manner.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that include responsibilities for key staff at an organisational level and the service level and is reviewed during this audit. The restraint co-ordinator is the senior RN and during interview they are able to describe the role and responsibilities of the position. Restraint co-ordinator's job description was sighted in the senior RNs personal file. The restraint approval group is part of the quality/staff meetings and meetings are held monthly - minutes sighted. All clinical staff have received education in restraint and competencies are current. All staff in contact with residents have received challenging behaviour education and staff in the dementia unit have specific training in dementia.</p> <p>An ARC requirement is met.</p>

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Assessments are completed for residents using restraint. The care plans reviewed indicates that the assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family. The consent form documents that the RN, family and GP are involved.  ARC requirement is met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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

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

Services use restraint safely

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The restraint assessment form identifies that the key relevant aspects of this standard is included in any assessment of restraint. There is an assessment process and it includes consultation with the resident and family and is reviewed on residents' file. A restraint register is maintained that records the nine restraint users and is reviewed.</p> <p>Monitoring forms reviewed for three residents using restraint provide evidence that residents using restraint are monitored on a regular basis, as per policy and information concerning care is recorded on the monitoring form.</p> <p>ARC requirement is met.</p>

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Restraint evaluation processes are documented in the restraint minimisation and safe practice policy, which is reviewed. The residents' files evidence that each episode of restraint is being evaluated at least monthly, and more often based on the risk to the resident.</p> <p>Meeting minutes reviewed and interview of the restraint coordinator indicates that restraint practices are discussed at restraint approval meetings, and individual residents are also reviewed. Restraint is also reviewed as part of the care plan evaluation as sighted in the two residents' files reviewed.</p> <p>ARC requirement is met.</p>

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

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation reviewed indicates that approved restraint for each resident is reviewed at least monthly and as part of their three monthly care plan review. This review is conducted with family and resident involvement.

Restraint usage across the facility is monitored and discussed at the quality/staff/restraint approval meetings - minutes sighted. A restraint minimisation and safe practice audit was completed in May 2013 and a challenging behaviour audit in September 2013.

The ARC requirement is met.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# NZS 8134.3:2008: 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

**Attainment and Risk:** FA

### Evidence:

The Ultimate Care Group (UCG) Limited corporate infection control management systems are in place at Aroha Lifecare along with infection control policies and procedures to guide staff on all matters relating to infection control. The infection control (IC) policies and procedures meet the needs of the organisation and provide information and resources to inform the staff on infection prevention and control.

Care staff interviewed confirm the infection control policies and procedures provide them with adequate guidance. The infection control programme has been reviewed and approved by the UCG Clinical Governance Group in August 2013. The delegation of infection control matters throughout the organisation is clearly documented along with an Infection Control (IC) Co-ordinator job description. The facility manager is the IC Co-ordinator. Job description for the IC Co-ordinator sighted on the facility manager's (FM) / IC Co-ordinator's personal file and outlines their responsibilities. The FM / IC Co-ordinator was not on site during this audit and the senior RN, who deputises for the FM in their absence, describes review of infection control matters at the facility. They also confirm the governing body receives regular reports on infection related issues through regular reporting systems as well as via the UCG electronic database.

Visual inspection provides evidence staff provide infection management precautions.

ARC requirement is met.

### 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.

**Attainment and Risk:** FA

### Evidence:

### Finding:

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff. The IC Co-ordinator / FM is a registered nurse with the relevant skills and resources necessary to achieve the requirements of this standard. During interview the senior RN reports that they are able to access laboratory personnel, GPs and other health care professionals for infection control advice as required.

Management and staff have access to relevant and current information, which is appropriate to the size and complexity of the organization. The senior RN reports ongoing in-service education is provided on-line and by the IC Co-ordinator. Review of training records provides evidence that education was provided on 11 July 2013 and again on 19 December 2013. The facility has RN cover 24 hours a day and care staff interviewed confirm either the FM or RN are available for management of infection control issues or advice as required. Care staff also confirm they have access to policies, procedures and resources to manage infection prevention and control.

ARC requirement is met.

#### 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain information of an appropriate level and are readily accessible to all personnel. UCG policies and procedures are developed and reviewed regularly in consultation with relevant service providers. The policies and procedures identify links to other documentation in the organisation (e.g. health and safety, quality and risk).

The audit and compliance manager from UCG head office and the senior RN advise the UCG clinical governance group are responsible for the management of review of policies and procedures, including the infection control programme and associated policies and procedures.

Staff interviewed confirm infection control policies and procedures are readily available for them.

ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Infection control education is provided to staff as part of their initial orientation. The senior RN, a RN, an EN and care staff interviewed advise the RNs provide one-to-one education as required.

Review of staff training records indicates infection control education was provided on 11 July 2013 and again on 19 December 2013. Care staff also access on-line education as part of the in-service education programme provided at Aroha Lifecare.

The senior RN advises infection control education is provided for residents on an as needed basis. FM/ IC Co-ordinator's personal file is reviewed and evidences their attendance at infection control education in November 2013.

ARC contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Review of documentation provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organisation. All infections are recorded on an 'Infection Control Summary Form' (which includes the criteria for infections) and on individual resident infection registers. Residents with infections have a 'Infection Data Care Plan' developed to address the infection and these are reviewed on residents' files.</p> <p>Results of surveillance are reported on the UCG electronic database. Collated reports with analysis of this infection surveillance data is reviewed.</p> <p>Clinical indicators are reported monthly to the combined quality/infection control/staff/health and safety meetings and via the 'Weekly &amp; Monthly Reports' to the governing body.</p> <p>Staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RNs and daily handovers. They also report this infection surveillance information is made available for them during hand over and at staff meetings. Staff also report copies of meeting minutes and graphs are provided for them.</p> <p>Infection control audits are completed as part of the internal audit programme and this was last completed in October 2013</p>

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

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

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

**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.

**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.)