# Scovan Healthcare Limited - Taurima Rest Home

## Current Status: 24 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

Taurima provides rest home level care for up to 30 residents. Occupancy on the day of the audit was 15 residents. The service has an implemented quality and risk management programme that includes management of complaints, incidents, and accidents, hazards with a health and safety programme in place. The service is owned by two directors with one (a registered nurse) designated as the manager. The manager/registered nurse is supported by the clinical leader/registered nurse with both being available on call after hours. Staff interviewed are knowledgeable and skilled with an implemented training plan in place. Staffing is appropriate for the number of residents currently in the service and more staff are rostered on if there is a higher acuity or a higher number of residents. The general practitioner, residents and family praised the service for the excellence of support provided.

The following improvements are required by the service related to; pain assessments, and controlled drugs documentation.

## Audit Summary as at 24 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 24 January 2014

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

### Organisational Management as at 24 January 2014

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

### Continuum of Service Delivery as at 24 January 2014

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

### Safe and Appropriate Environment as at 24 January 2014

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

### Restraint Minimisation and Safe Practice as at 24 January 2014

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

### Infection Prevention and Control as at 24 January 2014

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

## Audit Results as at 24 January 2014

### Consumer Rights

The service displays posters and pamphlets describing the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are provided with education around resident rights and apply these in practice. Residents have the opportunity to participate in a residents' meeting and there are annual satisfaction surveys for both residents and family.

Taurima has in place a policy for informed consent and advance directives. Required consent forms and advance directive forms are evident in resident files reviewed.

### Organisational Management

Taurima has established business and quality programmes, frameworks and plans that include policies and processes. Quality information is reported to monthly staff and quality meetings with data analysed around complaints, incidents, hazards, health and safety, any corrective actions from internal audits and satisfaction surveys.

Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly residents meetings and via annual satisfaction surveys.

The service has a documented rationale for determining staffing and caregivers report current staffing levels are sufficient to meet resident needs.

There is an annual in-service programme and staff interviewed demonstrate knowledge of aged care and a commitment to supporting residents to have the best life possible.

### Continuum of Service Delivery

The service has a policy for admission and entry for to the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The clinical leader/clinical leader/registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' goals and interventions have been identified in the resident lifestyle plans. There is evidence in the resident files that there is resident/ family/whanau and caregiver input into the six monthly reviews.

There is an improvement required around the implementation of pain assessments. The GP reviews the resident at least three monthly.

Medication education is provided annually for all staff responsible for administration of medicines. The clinical leader/clinical leader/registered nurses and caregivers have competed annual competencies. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. The medication charts are reviewed by the GP at least three monthly.

There is an improvement required around the administration of controlled drugs.

Food services and all meals are provided on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There is dietitian review of the four weekly menu. All staff are trained in food safety and hygiene.

### Safe and Appropriate Environment

Taurima rest home has a current building warrant of fitness. The environment is homely and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activity. All bedrooms have hand basins. There are adequate numbers of communal toilets and showers. Outdoor areas are readily accessible and safe. There is outdoor seating and shade. There is adequate equipment for the safe delivery of care. Chemicals are stored safely. The cleaning service maintains a tidy, clean environment.

### Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service does not have any residents currently requiring restraint or enablers.

A restraint and enablers register is maintained.

Education in restraint minimisation and managing challenging behaviours is provided for staff annually.

### Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical leader/registered nurse) is responsible for coordinating/providing education and training for staff. Infection control training is provided for staff at least annually with good attendance from staff.

The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of hand hygiene and surveillance of infection control events and infections.

There is a low rate of infections as sighted in the 2013 data graphed monthly.

There is an annual review of the infection control programme.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Scovan Healthcare Limited |
| **Certificate name:** | Scovan Healthcare Limited - Taurima Rest Home |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Taurima Resthome | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 24 January 2014 | **End date:** | 24 January 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 15 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXX | **Total hours on site** | 8 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 14 | Total audit hours | 30 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 5 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 15 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 0 |

## **Declaration**

I, XXXXXX , Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Thursday, 27 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Taurima provides rest home level care for up to 30 residents. Occupancy on the day of the audit was 15 residents. The service has an implemented quality and risk management programme that includes management of complaints, incidents, accidents, hazards with a health and safety programme in place. The service is owned by two directors with one (a registered nurse) designated as the manager. The manager/registered nurse is supported by the clinical leader/registered nurse with both being available on call after hours. Staff interviewed are knowledgeable and skilled with an implemented training plan in place. Staffing is appropriate for the number of residents currently in the service and more staff are rostered on if there is a higher acuity or a higher number of residents.  The general practitioner, residents and family praised the service for the excellence of support provided.  The following improvements are required by the service related to; pain assessments, and controlled drugs documentation. |

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| **Outcome 1.1: Consumer Rights** |
| The service displays posters and pamphlets describing the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about resident rights is also provided on admission to the facility. There is a complaints management process that meets the requirements of Right 10 of the Code. Staff and residents are aware of the complaints process and there is an up to date register documented. Resident values and beliefs are discussed in the initial assessment phase following admission and are documented in resident files. Staff are provided with education around resident rights and apply these in practice. Residents have the opportunity to participate in a residents' meeting and there are annual satisfaction surveys for both residents and family.  Taurima has in place a policy for informed consent and advance directives. Required consent forms and advance directive forms are evident in resident files reviewed. |

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| **Outcome 1.2: Organisational Management** |
| Taurima has established business and quality programmes, frameworks and plans that include policies and processes. Quality information is reported to monthly staff and quality meetings with data analysed around complaints, incidents, hazards, health and safety, any corrective actions from internal audits and satisfaction surveys.  Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly residents meetings and via annual satisfaction surveys.  The service has a documented rationale for determining staffing and caregivers report current staffing levels are sufficient to meet resident needs.  There is an annual in-service programme and staff interviewed demonstrate knowledge of aged care and a commitment to supporting residents to have the best life possible. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a policy for admission and entry for to the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The clinical leader/clinical leader/registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' goals and interventions have been identified in the resident lifestyle plans. There is evidence in the resident files that there is resident/ family/whanau and caregiver input into the six monthly reviews. There is an improvement required around the implementation of pain assessments. The GP reviews the resident at least three monthly.  Medication education is provided annually for all staff responsible for administration of medicines. The clinical leader/clinical leader/registered nurses and caregivers have competed annual competencies. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. The medication charts are reviewed by the GP at least three monthly. There is an improvement required around the administration of controlled drugs.  Food services and all meals are provided on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There is dietitian review of the four weekly menu. All staff are trained in food safety and hygiene. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Taurima rest home has a current building warrant of fitness. The environment is homely and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activity. All bedrooms have hand basins. There are adequate numbers of communal toilets and showers. Outdoor areas are readily accessible and safe. There is outdoor seating and shade. There is adequate equipment for the safe delivery of care. Chemicals are stored safely. The cleaning service maintain a tidy, clean environment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service does not have any residents currently requiring restraint or enablers.  A restraint and enablers register is maintained.  Education in restraint minimisation and managing challenging behaviours is provided for staff annually. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (clinical leader/registered nurse) is responsible for coordinating/providing education and training for staff. Infection control training is provided for staff at least annually with good attendance from staff.  The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of hand hygiene and surveillance of infection control events and infections.  There is a low rate of infections as sighted in the 2013 data graphed monthly. There is an annual review of the infection control programme. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 8 | 0 | 0 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | One resident on controlled drug pain relief does not have a pain assessment completed. | Ensure residents who identify pain or on regular/prn pain relief have a pain assessment completed. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Two caregivers check out the controlled drug not at the time of administration, this is kept securely stored until required. | Ensure controlled drugs are only checked out at the time of administration. If there is only on caregiver on duty at the time, ensure the controlled drug balance is signed for in the controlled drug register when the second caregiver comes on duty. | 30 |

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place.  The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Staff receive training for rights at induction and ongoing – last provided in November 2013 – facilitated by the Nationwide Health and Disability Advocacy Service. Staff have received training in April 2013 around resident rights.  Discussions with staff interviewed including the two caregivers and clinical leader show an understanding of the key principles for the Code in providing services. Five of five residents interviewed state that their rights are upheld and staff treat them with respect and give dignity to them. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a welcome information booklet/folder that includes information about the Code and advocacy services and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and, as appropriate, their legal representative.  On-going opportunities occur via regular contact with family to discuss any issues as they arise. This includes monthly resident/family meetings and accessibility to the clinical leader and the manager/registered nurse, both of whom have an open door policy. Advocacy pamphlets are clearly displayed on site.  Interviews with five of five residents interviewed all confirm that information has been provided around advocacy.  D6, 2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) pamphlet, advocacy and information around the Health and Disability Commission. |

##### **Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)**

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident private areas. The service has a policy in place that includes that personal belongings are not used as communal property. Two caregivers interviewed describe ensuring privacy by knocking before entering.  Values and beliefs information and resident preferences are gathered on admission with family involvement and is integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with two caregivers identified how they get to know resident values, beliefs and cultural differences. Interviews with five residents confirms that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with two caregivers and the clinical leader/registered nurse describe providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities.  There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years.  Abuse and neglect training was last delivered in July 2012 to staff and the 2014 calendar includes training around abuse and neglect.  D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Elderly abuse prevention training occurs at orientation and on a two yearly basis and includes professionalism and standards of conduct. Training last occurred in July 2012 as part of the code of rights training and eight staff members attended. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy – Recognition of Maori values and beliefs – guidelines for the provision of culturally safe services for Maori residents that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.  Staff receive cultural training – last provided in May 2013.  Cultural needs and support is identified in care plans.  There is one resident who identifies as Maori and the care plan includes that there are no specific requirements or needs. The manager/registered nurse describes offering Tui Ora services to the resident including having someone come into talk in te reo but the offer was declined.  There are three Maori caregivers who can provide support and advice. Two of the three speak te reo and are involved in their own marae and support any Maori resident who dies in the service. A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).  D20.1i The service has developed a link with Tui Ora with a letter dated 20 December 2013 from Tui Ora confirming the offer of cultural support.  The policy and Maori health plan identifies the importance of family/whānau and two caregivers and the clinical leader interviewed discuss the importance of family involvement.  Discussion with three family members confirm that they are regularly involved. |

##### **Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)**

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences.  D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and including any needs in the plan and review. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans (sighted in Five of five resident care plans). D4.1c During the admission process, the clinical leader or the manager/registered nurse along with the resident and family whenever possible complete the documentation and this includes recognition of the resident culture, values and beliefs – sighted in care plans and confirmed on interview with the clinical leader and the manager/registered nurse. There is a monthly interdenominational church service and the minister is able to provide support when required and to bless rooms after a resident has died. Two residents attend their own church services in the community and specific ministers are asked to provide support at the direction of individual resident requests. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings.  The manager/registered nurse, two caregivers and the clinical leader interviewed are able to describe appropriate boundaries between staff and residents and their families.  Five of five residents interviewed and three of three family interviewed did not identify any incidents related to discrimination and there are no incidents citing discrimination noted on review of the incident forms and incident data for 2013.  Care plans reviewed (five of five) include the residents social, spiritual, cultural and recreational needs. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a thorough and individualised quality and risk management programme that includes leadership from the manager/clinical leader/clinical leader/registered nurse. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training.  A2.2: Services are provided at Taurima that adhere to the health and disability services standards.  There is a business plan 2014-15 and this guides the quality programme.  The manager/registered nurse has worked to ensure that all policies brought into the service since the purchase are embedded and the policies truly reflect rest home level care with documentation relevant now to the residents in the service. Roles including clinical leadership roles are clearly defined and implemented.  Five of five residents interviewed and three of three family interviewed praised the service for the Taurima use of resident centred care and the participation of residents and family in service delivery. These models ensure that staff liaise with the resident for the best outcome. The management team including the manager/registered nurse, clinical leader/registered nurse and the second owner/director are looking at ways to improve resident’s lives through the quality and risk management programme and through a team approach to management and leadership. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy around communicating effectively with residents and family including open disclosure.  Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The MoH “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b Three of three relatives state that they are always informed when their family members health status changes. D11.3 The information pack is available in large print and advised that this can be read to residents. Policies and training support staff in providing care and support so that residents can make choices and be involved in the service.  Interviews with two identify that consents are sought in the delivery of personal cares and this is confirmed by five of five residents.  Incident forms reviewed (10 of 10 in November and December 2013) indicate that family are informed following an incident. There are no residents currently who identify as requiring an interpreter however the staff are able to describe how an interpreter would be accessed. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes the following: collection, storage and release of information too relevant personnel, photograph for display and identification purposes, name on bedroom door and consent to emergency treatment. Specific consents are obtained for procedures such as influenza vaccines. All resident files have a resuscitation order that is signed by the resident and the GP. The resuscitation form is reviewed annually.  D13.1 There were five admission agreements sighted and all had been signed.  D3.1.d Discussion with five residents and three relatives identified that the service actively involves them in decisions that affect their lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Advocacy information is part of the service entry package and is on display in the facility.  The right to have an advocate is discussed with residents and their family during the entry process and relative or nominated advocate is documented on the front page of the resident file as confirmed by the residents and family interviewed – sighted in five of five files reviewed D4.1d; Discussion with three of three family interviewed identifies that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e: The resident file includes information on resident’s family/whanau and chosen social networks as sighted in five of five files reviewed.  The complaints folder indicates that complainants are informed that they can access advocacy services to support them if needed and an information sheet is given to any complainant with this including the name and phone numbers of the advocacy service. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has visiting arrangements that are suitable to residents and family. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations. D3.1: Discussion with three of three family indicates that they are encouraged to be involved with the service and care including being informed of care planning reviews with an invitation to participate. D3.1.e: Discussion with staff and relatives indicates that they are supported and encouraged to remain involved in the community and external groups such as church, shopping, events in the community, library.  Visiting in the service can occur at any reasonable time. Interviews with four residents and three relatives confirm visitors are welcome and visitors were sighted coming and going on the days of the audit. There are two forms in each resident file: a) a contact form re who to contact in the event of an incident and a form re when to contact a family member; b) a phone record of contact with family. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D13.3h. The service has in place complaint management policies and procedures that are aligned with Code 10 of the Code of Rights. A complaints register/folder is in place that documents complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau as stated by five of five residents interviewed and three of three family interviewed. The entry pack includes a summary of the complaints procedure.  The complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution.  Two complaints reviewed for 2013 (of six in total) were tracked, indicating that they had been actioned according to timeframes and identified resolution. The quarterly management meeting includes discussion of complaints and opportunities for improvement in service delivery. Residents and family confirm they are aware of the complaints process and they would make a complaint to the managers if necessary. There are no complaints with the Health and Disability Commissioner, District Health Board or Ministry of Health in the last year. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Taurima is a 30 bed facility that currently provides rest home level care for 15 residents.  There is a business plan 2014-15 that includes goals, objectives and actions with identified responsibilities and timeframes.  The philosophy is 'yes, we can do that for you'. This is documented in the policy manual.  Quarterly management meetings are held with the manager/clinical leader/clinical leader/registered nurse (director), second director and the clinical leader present. All aspects of the quality programme are reviewed and a risk management plan documented is also reviewed through these meetings.  The service is managed by the owners with one of the owners (registered nurse) on site two days a week and the other providing support as required. She is supported by the clinical leader/registered nurse) who is designated as the manager for the other days of the week with the two taking the on call role.  ARC,D17.3di (rest home) The manager/registered nurse states that she has maintained at least eight hours annually of professional development activities related to managing a rest home. The clinical leader/registered nurse has maintained at least eight hours annually of professional development activities related to managing a rest home – training records sighted. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality and risk management programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. In the temporary absence of the manager/registered nurse, the clinical leader assumes responsibility of the service with both the manager/registered nurse and the clinical leader stating that even when the manager/registered nurse is absent, the phone is always answered and this includes when the manager/registered nurse is offsite.  The clinical leader/registered nurse has been with the service for over 15 years and has considerable experience in aged care. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Taurima has a documented quality and risk management system. Interviews with the manager/registered nurse, clinical leader/registered nurse, two caregivers, one cook, an activities officer and a review of meeting minutes demonstrate a culture of quality improvements that have started with the new management. The owners have embedded new policies and procedures based around eight service goals. Any internal audit is linked to the service goals. Policies include the following: continence assessment and management, pain management and pain assessment form, skin management, wound care, a transport and transportation of resident's policy and death of a resident. There is a document control process in place that includes date of review and date of next review.  Resident/family meetings are held monthly and allow residents to express any concerns – meeting minutes sighted.  The service has a health and safety system.  There is an internal audit schedule and internal audits are completed as per schedule. Action plans are documented on the form and are signed off to show resolution of issues.  There are staff meetings held four to six weekly and management meetings held quarterly with evidence of discussion of the all components of the quality and risk management programme.  Resident/relative surveys are completed annually – last circulated in September 2013. All respondents state that they are happy with and satisfied with the service provided. This is also confirmed by three of three family interviewed and five of five residents interviewed. D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. The hazard register is up to date with evidence of resolution of issues.  D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.  There is monthly accident/incident collation of data and monthly surveillance of infection reports. The service has linked the complaints process with its quality management system through the quarterly management meetings. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The manager/registered nurse is able to identify that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH.  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.  Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.  A review of incidents (10 of 10) indicates that any incidents are reviewed by the manager/registered nurse with monthly summaries completed. If there is an immediate need, the clinical leader/registered nurse also reviews the incident form.  Incidents and accidents are discussed at the management and staff meetings.  Family interviewed confirm that they are informed of incidents as these occur. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five of five staff files reviewed include a signed contract, police check, and orientation on file. The caregiver interviewed who has been with the service for 10 months states that she had an excellent orientation that included review of policies and procedures, tour, meeting all staff and residents and buddying on each shift.  A register of clinical leader/registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Practicing certificates for other health practitioners are retained to provide evidence of registration as appropriate (for example dietician) - sighted all as being current. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.  Training records are kept for each staff member and certificates of training are kept on file. There is an implemented training plan for 2013 with the 2014 training plan documented. The annual training programme well exceeds eight hours annually noting that there is a large number of staff attending each session.  Five of five staff files reviewed include a current annual performance appraisal.  The clinical leader/registered nurse is supported to maintain their professional competency with the clinical leader/registered nurse having completed well over eight hours training with the District Health Board.  D17.7d: There are implemented competencies for medication.  Interviews with the two caregivers and clinical leader identify staff who are knowledgeable and have considerable experience in aged care. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are established policies around the management of staff skill mix including contractual obligations and the acuity of residents within the service. The manager/registered nurse is supported by a clinical leader/registered nurse (20 hours a week). The manager/registered nurse is on site for two and a half days a week with overlap of the clinical leader/registered nurse. There is a diversional therapist (25 hours a week), two cooks who cook all meals, two cleaners, one maintenance and eight caregivers. The clinical leader/registered nurse and manager/registered nurse are on call.  Currently there are two staff on morning and afternoon shift (one full and one half shift) and one staff overnight. This meets the acuity needs and number of residents currently in the service (15).  Two caregivers interviewed and the clinical leader state that there are sufficient staff on at all times.  Five of five residents interviewed and three of three relatives report staff are available to meet their needs and there are sufficient staff to provide support at all times. Physiotherapy services are provided by an external provider when required. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Policies outline security of records. Files are kept in a secure cupboards behind the nurses’ station.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.  D7.1 Entries are legible, dated and signed by the relevant caregiver or staff member with progress notes documented on each shift. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A placement authority approval form is required from the needs assessment team prior to entry for rest home level of care.  The clinical leader/registered nurse and the manager/registered nurse are responsible for the screening of residents to ensure entry has been approved. Enquiry forms are completed for potential clients. The resident/family are invited to view the facility and receive an information pack. A suitable admission day and time is arranged with the resident/family and clinical leader/registered nurse. The resident and family receive an orientation to the facility.  Five residents and three relatives interviewed state they received all relevant information prior or on admission. The general practitioner is notified of a new admission.  The information pack includes all relevant aspects of service and associated information such as the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and how to access advocacy.  There is an admission procedure in place and admission documentation which includes resident and next of kin details. The clinical leader/registered nurse (interviewed) is able to describe the entry and admission process. Five signed admission agreements are sighted.  D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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

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

ARHSS D4.2

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D.16.2, 3, 4: The five rest home resident files sampled identifies the clinical leader/registered nurse completes an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP (general practitioner) health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial care plan. Long term lifestyle plans are developed within three weeks. The resident/family/whanau sign the care plan acknowledging their involvement in the development and review of the six monthly lifestyle plans. The clinical leader/registered nurse amends the long term lifestyle plan to reflect ongoing changes as part of the review process. Resident files sampled include a family contact form that details when a relative is contacted and the concern/issue.  Allied health professionals involved in the residents care maintain progress notes in the integrated resident file.   D16.5e: Five resident files sampled identified that the GP had seen the resident within two working days. It was noted in five of five resident files sampled that the GP had examined the resident three monthly and carried out a medication review. Residents retain their own GP.  The GP visits more frequently as requested by the clinical leader/clinical leader/clinical leader/registered nurse for resident concerns. Faxes to the GP and responses are sighted in the resident files. A GP summary form of visits with dates and actions is kept in each resident file. The families are notified of planned GP visits and invited to attend. The local accident and medical centre can be accessed after hours. The GP is unavailable for interview.  There is a verbal handover period between the shifts to ensure staff are kept informed of resident’s health status and any significant events. Progress notes are written on each shift. A communication book in the nurse’s office records tests and investigations, appointments and memos to staff and clinical leader/registered nurse.  Resident foot and nail care is provided by a local foot care service.   Tracer methodology Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication requirements, activities of daily living, elimination, mobility status, nutritional needs, activities preferences, spiritual and cultural needs, privacy and sexuality, comfort and pain management. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the clinical leader/registered nurse to develop the initial assessment and the first resident lifestyle plan within the required timeframes.  All resident files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives and residents advised on interview that assessments were completed in the privacy of their single room.  A range of assessment tools is completed on admission if applicable including (but not limited to); a) Coombes falls risk, b) Waterlow pressure area risk assessment, summary and actions, c) continence and bowel assessment, and d) wound assessment (as applicable). |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The clinical leader/registered nurse develops the long term lifestyle plan from information gathered over the first three weeks of admission. The long term lifestyle plan has categories of care as follows: hygiene, nutrition, sleep, mobilising, privacy/sexuality, spiritual and cultural, bladder/bowel management, skin care, social, hearing and vision, comfort and pain management and medication requirement.  The lifestyle plan details the resident’s abilities, disabilities, goals and interventions. Each resident has a risk management plan that details the risk and interventions required. Examples sighted are clinical risk for insulin dependent diabetic and significance of blood sugar levels, interventions and management of diabetes. Risk management plans are used for behavioural risks and include early warning signs and symptoms, interventions and management required for behavioural problems.  The resident file includes admission documentation, general consents, nursing care plans, medical notes, diversional therapy documentation and correspondence. There is a separate folder that contains progress notes and a Quick Guide care plan for caregiver reference. Short term care plans are also kept in the progress notes folder. Caregivers interviewed are knowledgeable regarding resident cares, care plans and communication systems.  D16.3k, Short term care plans are used to document short term changes in health needs. Short term care plans are evaluated regularly. Short term care plans sighted are for eye infection and UTI.  D16.3f; Five out of five resident files reviewed identified that family have been involved in care planning development and reviews. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D18.3 and 4 Dressing supplies are available. All staff report that there are adequate continence supplies and dressing supplies. There are no wounds currently being managed. There is evidence of healed wounds that have had full wound assessments completed, wound monitoring forms completed and evaluated. Short term care plans are completed for wounds and skin tears that describe the problem, goal, interventions and evaluations. There is access to wound management specialist by GP referral. There is evidence of a previous referral to the ulcer clinic. Staff attended wound management August 2013.  Continence products are available and resident files include a urinary and bowel continence assessment. Resident bowel charts are maintained. Specialist continence advice is available as needed by GP referral. Staff attended continence education March 2013.  Risk management plans are used for behavioural risks and include early warning signs and symptoms, interventions and management  required for behavioural problems. The community mental health nurse is available for visits and liaises with the mental health for older person’s team. Four of five resident files did not identify pain and pain assessments are not applicable. One resident on controlled drug pain relief does not have a pain assessment completed. Comfort and pain is included in the resident lifestyle plan.  An improvement is required to documentation of a pain assessment for a resident on controlled drugs for pain relief. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Four of five resident files did not identify pain and pain assessments are not applicable. Comfort and pain is included in the resident lifestyle plan template. |
| **Finding:** |
| One resident on controlled drug pain relief does not have a pain assessment completed. |
| **Corrective Action:** |
| Ensure residents who identify pain or on regular/prn pain relief have a pain assessment completed. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employs an activity officer for 25 hours per week from 9.30am to 3pm. The activity officer has been employed for five months, has previous experience in activities and is progressing through the diversional therapy qualification (DT). The activity officer attends the two monthly DT workshops.  There is a weekly programme displayed. The programme includes exercise, bowls, board games, painting, pampering, golf putting, cards, and weekly entertainment. Community visitors include RSA visits and church groups. There is a hairdressing service available. A volunteer is involved in assisting with card groups. The wheelchair ironside van is hired for fortnightly outings such as drives to the beach, picnics, viewpoints and other places of interest. The activity officer spends one on one time with residents who do not choose to participate in group activities. There are monthly resident meetings where residents may offer suggestions for activities and provide feedback on the programme.  An activities assessment is completed on admission in consultation with the resident/family/whanau. Individual activity care plans are reviewed six monthly. There is documented evidence of resident/family/whanau participation in the review of care plan. Activity progress notes are written daily and resident attendance sheets are maintained.  D16.5d: The review of activity care plans is to be co-ordinated with the review of new format of clinical lifestyle plans (refer 1.3.8.) |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical leader/registered nurse completes a written evaluation of the long term lifestyle plan six monthly. Risk tool assessments where applicable are reviewed at least six monthly. Caregivers are involved in the review process. The clinical leader/registered nurse completes a resident clinical review prior to the written evaluation. There is evidence of the resident/family/whanau involvement in the care plan review. Short term care plans are reviewed regularly with problems resolved or added to the long term lifestyle plan if an ongoing problem. The GP conducts a three monthly resident review and medication review. The clinical leader/registered nurse is in the process of changing care plans over to a new format as evaluations are due. The review of activity care plans is being co-ordinated with the review of long term lifestyle plans.  D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated ARC D16.3c: All initial care plans are evaluated by the clinical leader/registered nurse within three weeks of admission |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. All referrals are made by the GP in consultation with the clinical leader/registered nurse and family. The clinical leader/registered nurse may contact mental health elderly services, social worker, occupational therapist and needs assessment team directly. The GP is also notified. Examples of referrals sighted are; ulcer clinic, dermatologist, older persons mental health team, community mental health nurse, social worker, psychogeriatrician and diabetic educator. D16.4c; There are no residents currently requiring re-assessment.  D 20.1. Discussions with the clinical leader/registered nurse identifies that the service has access to nursing specialists such as wound, continence, palliative care nurse and other allied health professionals such as dietitian, speech language therapist and other allied health professionals. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical leader/registered nurse (interviewed) described the transfer documentation (DHB transfer form, medication chart, resuscitation status and any special information relevant to the residents transfer) that is sent with the resident for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. The service have pre-printed transfer forms with all resident details. The green bag medication system is used for transfers to the local DHB. Families are informed of transfers and encouraged to accompany the resident to hospital. A staff member will escort residents to hospital as required. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are medication policies and procedures in place. The clinical leader/registered nurse and caregivers administer medications and complete annual competencies. Medication education has been completed six monthly (May and November 2013) with an external trainer. Caregivers complete a medication orientation, written test and supervised medication rounds before being signed off by the clinical leader/registered nurse as competent to administer medications. Current standing orders are in place. There is one self-medicating resident. Self-medication competency is completed and reviewed six monthly. The medication is stored in a locked drawer in the resident’s bedroom. The medication person observes the resident administering the medication and signs the signing sheet.  Hospice administer of syringe driver medications if required for palliative care residents. The supplying pharmacy deliver the monthly blister pack medication. The RN completes a medication reconciliation on monthly medications and signs the top of the blister pack. The clinical leader/registered nurse writes a memo into the communication book informing staff the medication the check has been completed. There are individual medication reconciliation forms for resident transfers/return into the facility. Prn medications are packed and checked weekly. There are adequate pharmaceutical supplies. The medication fridge is temperature monitored and cleaned weekly. All eye drops in use are dated on opening.  The controlled drug safe is kept in a secure area. The controlled drug register evidences weekly controlled drug checks. Ten medication charts sampled all have photo identification and allergies noted. There are no gaps on the administration signing sheets.  D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart is signed. There is an improvement required around the signing of controlled drugs. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Controlled drugs are stored in the controlled drug safe. There are weekly controlled drug checks. Taurima is rest home only with one caregiver on at night. There is one resident who often has a controlled drug elixir during the night. This is checked out by two caregivers before the afternoon caregiver goes off duty and it is stored in the CD safe and administered by the only night shift caregiver when required. If given during the night the CD register is signed a second person when they come on morning shift. If not given then the medication is checked back in. |
| **Finding:** |
| Two caregivers check out the controlled drug not at the time of administration, this is kept securely stored until required. |
| **Corrective Action:** |
| Ensure controlled drugs are only checked out at the time of administration. If there is only on caregiver on duty at the time, ensure the controlled drug balance is signed for in the controlled drug register when the second caregiver comes on duty. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.2 Staff have been trained in safe food handling. The service employs a daily cook from 6am to 1pm and a tea shift person form 3.30-7pm. The four weekly menu has been reviewed by the dietitian. Menu changes have been implemented and signed off by the dietitian (sighted). The cook maintains a diary to record the daily menu and any changes made. Resident dietary profiles are forwarded to the kitchen. Resident likes and dislikes are known. Gluten free and vegetarian meals are provided. The main meal is at midday. The clinical leader/registered nurse notifies the kitchen of any resident dietary changes. There is no evidence of hot food monitoring. Fridge and freezer temperature monitoring is carried out weekly. All foods in the fridge is date labelled. Dry goods in the pantry are sealed and dated. Residents have the opportunity to feed back on the food services at the resident meetings. Internal audits are completed annually. Staff attended food safety education in January 2013. Certificates are displayed in the kitchen. An external supplier provides the chemicals, product wall charts, safety data sheets and education (completed September 2013). There are fly screens on the windows. The fire blanket has been checked. Cleaning duties are completed by the tea shift person and night shift caregivers. The high walls and ceilings are completed by the maintenance person. Improvement Note: The service should consider monitoring of hot food temperatures. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. All chemicals are locked in a chemical store cupboard. There is an incident reporting system that includes investigation of incidents. Safety data sheets are readily accessible. There is appropriate protective equipment and clothing for staff. Staff attended chemical safety September 1013. Infectious waste products are double bagged prior to disposal. Waste management bins are collected by an external contractor. Staff attended infection control in-service April 2013. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building has a current warrant of fitness which expires 29 September 2015. There is a maintenance person employed for 20 hours a week. Daily maintenance requests are addressed and signed off in the maintenance request book. The maintenance person is available on call for urgent facility matters. There is a maintenance programme in place for weekly, monthly and six monthly checks that includes resident equipment, internal and external buildings. Electrical equipment has been tested and tagged February 2013.  Hot water temperature monitoring is completed monthly with readings within acceptable ranges.  The interior of the home is well maintained and homely. There is a refurbishment plan in place includes re-painting the interior communal areas. Carpets have been replaced in the communal areas. Residents are observed to be moving freely around the facility with the use of mobility aids. Handrails are appropriately placed. There is easy access to the outdoor areas and gardens. Ramps and rails lead to the outdoor area. There are spacious outdoor areas with shaded seating. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequate numbers of toilets and showers for each wing. There is safe flooring, seating and hand rails appropriately placed in the shower rooms. There are privacy locks on the doors. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares. All bedrooms have hand basins. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are single rooms. One bedroom can be doubled if required. The bedrooms are personalised and spacious enough for residents to move safely around the room with the use of mobility aids. The staff report there is adequate space to carry out the resident cares and for the use of resident equipment as required. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is easy access to the communal areas. Activities take place in the large main lounge. There is a smaller lounge/library with outdoor access to a deck area. There is a separate dining area. A resident telephone is available. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a dedicated cleaner/laundry person employed for four and a half hours a day from Monday to Friday. The cleaner’s trolley is well equipped and chemicals are correctly labelled. The trolley is stored safely when not in use. Caregivers complete cleaning duties in the weekends. Caregivers complete laundry duties. Laundry procedures and cleaning duties are sighted. Safety data sheets are readily accessible. Staff are observed wearing protective clothing when carrying out laundry and cleaning duties. The sluice room has keypad access. Chemicals are stored safely. Staff have attended chemical safety training September 2013. Annual cleaning and laundry audits and resident meetings provide feedback on the service. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.6: There are emergency management plans in place around health and safety, civil defence and other emergencies. There are ample supplies of equipment required for emergency situations. There are fire extinguishers and information on how to respond to a fire and evacuation information strategically placed throughout the facility. Six monthly fire evacuation practice documentation sighted and these have been completed as per policy.  There is a barbecue for cooking, extra water in a storage tank, back-up lighting and torches with a good supply of batteries available. Extra blankets were sighted in a cupboard.  Alarms are serviced monthly with review of emergency systems documented. Emergency kits are checked monthly.  There is a barbecue for cooking, extra water in a storage tank, back-up lighting and torches with a good supply of batteries available.  There is an approved evacuation plan dated 16 January 2014.  There are policies and procedures in place relating to security. Doors are locked in the evening. Residents and family state that the service is safe. Resident support needs is identified in the care planning process and where additional needs are identified these are met by the service. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate natural light in all communal rooms. Bedrooms have at least one window to allow natural lighting and opens safely to allow for ventilation. There are safe heating units in each wing. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint minimisation manual applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective with the service The policies and procedures are comprehensive, included definitions, processes and use of enablers. The restraint minimisation manual includes that enablers are voluntary and the least restrictive option. There are no enablers and no restraints. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008.  There are clear lines of accountability to report to the manager/registered nurse and/or the clinical leader/registered nurse who both monitor infection control.  There is an IC (infection control) responsibility policy that includes chain of responsibility and an IC role description.   The clinical leader/registered nurse who oversees the infection control coordinator can describe how the service would manage an outbreak and there are individual policies such as scabies management policy. There have been no outbreaks since the previous audit. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical leader/registered nurse is the infection control coordinator and IC matters are taken to the monthly staff / quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. She is responsible for reviewing the IC programme annually. The clinical leader/registered nurse complies with the objectives of the infection control policy and works with all staff to facilitate the programme.  The clinical leader/registered nurse has attended IC training provided by Bug Control in 2013.  Staff have completed infection control education in 2013 with most staff members attended. The infection control coordinator states that others who were not able to attend were reminded of infection control through interactions with the clinical leader/registered nurse. Access to specialists from the DHB, laboratories, Bug Control and GPs is available for additional training support.  The clinical leader/registered nurse has access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Taurima has infection control policies and an infection control manual which reflect current practise.  The IC programme defines roles and responsibilities of the IC coordinator.  The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator.  The IC programme is reviewed annually by the IC coordinator who can access external specialist advice to for advice if required.  D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The IC coordinator is the clinical leader/registered nurse. She has attended external specialist training.  All new staff receive infection control education at orientation including hand washing and preventative measures with completion of orientation documented in five of five staff files reviewed. Infection control education has been delivered in 2013. The training folder records the staff education and attendance.  External resources including DHB, labs, Bug Control and GP's ensure the content of the education sessions are current and reflect best practice.  Resident education occurs as part of care delivery.  There is evidence of consumer and visitor education around influenza and Norovirus. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained and this is able to be described by the clinical leader/registered nurse and manager/registered nurse interviewed.. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the infection control (IC), coordinator who is the clinical leader/registered nurse. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Taurima are appropriate to the acuity, risk and needs of the residents.   The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff and monthly quality meetings that include a cross section of staff (minutes viewed).  The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility  Monthly internal audit of infection control is included in the annual programme and was last conducted in December 2013. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided.  The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. This was evidenced during the October 2012 outbreak of Norovirus. General practitioners are notified if there is any resistance to antimicrobial agents.  There is evidence of general practitioner involvement and laboratory reporting in five of five files reviewed. |

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

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

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

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

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

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