

Chetty's Investment Limited

Current Status: 18 February 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

Alexander Lodge Rest Home is a 23 bed facility located in South Auckland and provides rest home level care. At the time of audit there are 17 residents receiving care, and one boarder. Four of the residents are aged under 65 years of age. The owner purchased this rest home in April 2013 and works on site most days. There have been no changes to the services, building or environment since the last audit with the exception of an ongoing refurbishment programme and replacement of some equipment and furnishings.

Monitoring of the quality and risk programme is overseen by an independent quality adviser. An experienced registered nurse provides nursing services.

At this audit there were no areas identified as requiring improvement.

Audit Summary as at 18 February 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

Indicator	Description	Definition
	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 18 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 18 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 18 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 18 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 18 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 18 February 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 18 February 2014

Consumer Rights

Alexander Lodge Rest Home implement processes that demonstrate their commitment to ensuring residents' rights are respected during service delivery. As observed, staff knowledge and understanding of residents' right is embedded into everyday practice. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) clearly displayed at the facility.

Residents are provided with care and services that allow them to maximise their independence and to ensure their needs are met. Resident and family interviews confirm their satisfaction with the staff and provision of services. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

There a Maori Health Plan in place that identifies how the service responds to residents who identify as Maori. Currently there are no residents who identify as Maori. Recognition and respect for all individual's cultural, values and beliefs is well managed by the service and clearly documented during the assessment and care planning process.

Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice with specialist input as is appropriate. Documentation and interviews confirm there is effective and honest communication between service providers, other health professionals, such as mental health services, residents and family. Residents have visitors of their choice and are actively encouraged to maintain links with family, friends and community.

The right to make a complaint was well understood by residents and family members interviewed as well as staff and the owner/manager. There have been no complaints received since the owner purchased the facility.

Organisational Management

The owner purchased Alexander Lodge Rest Home in April 2013 and is supported by an experienced registered nurse (RN) who has worked in this rest home since 2008. Both the owner/manager and the RN participate in relevant ongoing education. The Alexander Lodge Rest Home business plan and quality and risk plan provide the framework for all services provided. The vision, mission and goals of the rest home are clearly documented. Many of the goals for 2013 related to facility refurbishment or replacement of equipment. These goals are noted to be met.

The quality and risk programme includes complaints, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk/hazard identification and management. The quality and risk programme is facilitated by an independent quality adviser (QA) who developed the programme and works on site at least one day a week. The QA also developed and reviews all policies/procedures. The results of quality and risk activities are discussed with staff regularly at the monthly staff meetings or sooner during shift handover where applicable. Corrective action plans are developed, implemented and monitored for effectiveness.

Residents and family are included in all aspects of service planning and delivery. This was verified with all residents and family members interviewed.

Current accepted human resource processes are implemented, including prospective employees completing an application form. Interviews are conducted and reference checks obtained. Staff are provided with an employment contract and job description. Where staff or contractors are required to have an annual practising certificate (APC), these are monitored and all are current.

New staff complete an orientation programme. Staff participate in regular on-going education. Staffing numbers meets the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB). There is a staff member on duty at all times with a current first aid certificate.

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

Continuum of Service Delivery

The service maintains documented entry criteria and there are processes in place should a resident be declined service. At the time of audit the service has not declined entry where the resident has an appropriate assessment and a bed is available.

Residents receive timely, competent and appropriate services in order to meet identified goals. Assessment, care planning, review and evaluation of care show how outcomes are achieved via multidisciplinary teams. Resident and family input into planned care is well documented. Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

The service provides planned and spontaneous activities for all age groups and needs levels. The residents are involved in this process to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests.

Residents receive medicines in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements, including cultural and personal likes and dislikes.

Safe and Appropriate Environment

Alexander Lodge Rest Home has 19 single occupancy rooms and two share twin occupancy rooms. Sixteen of the resident rooms are located on the ground floor, with five residents' rooms, including the two share twin rooms, being located on the first floor. There are processes implemented to ensure residents who are living on the first floor are independently mobile. An elevator is also present between the ground and first floor for use if required. There are sufficient toilets and showers for residents.

The laundry and garage is located in the basement and are accessible to staff only. The building has a current building warrant of fitness. Clinical equipment has evidence of current performance monitoring. Electrical equipment sighted did not initially have evidence of electrical safety checking. This was addressed by an external contractor during audit. Over the last year some improvements have been made in the facility with some rooms and corridors painted and new equipment purchased.

There is an approved fire evacuation plan and staff are trained in emergency and fire evacuation procedures. There are adequate supplies and equipment available and designated for use in an emergency. There is a staff member with a current first aid certificate on duty at all times.

Staff dispose of waste and hazardous substances in accordance with the organisation's policies. Chemicals are stored in a locked cupboard.

Residents and family members interviewed confirm the building is appropriately clean, ventilated and warm. There is a separate dining room and lounge area on the ground floor and a lounge area on the first floor. External areas are accessible to all residents and family members, including those requiring the use of mobility devices. There is an outside designated smoking area.

Restraint Minimisation and Safe Practice

The service has policies and procedures in place that identify safe restraint minimisation practices. Currently there are no restraints or enablers in use. Staff receive appropriate education and can verbalise the processes to be undertaken should restraint be required. Enablers are clearly described as the least restrictive option to ensure resident safety.

Infection Prevention and Control

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the registered nurse who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Residents are offered annual influenza vaccinations (with prior consent). There have been no reported outbreaks of infections at this facility in the last year.

HealthCERT Service Provider Audit Report (version 5.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability 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

Legal entity name:	Chetty's Investment Limited
Certificate name:	Alexander Lodge Rest Home

Designated Auditing Agency:	DAA Group Limited
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Types of audit:	Certification
Premises audited:	5 Alexander Street, Otahuhu, Auckland
Services audited:	Rest Home Care Residential Disability Services: Psychiatric
Dates of audit:	Start date: 18 February 2014 End date: 19 February 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	17
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Audit Team

Lead Auditor	XXXX	Hours on site	12	Hours off site	8
Other Auditors	XXXX.	Total hours on site	12	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXX			Hours	4

Sample Totals

Total audit hours on site	24	Total audit hours off site	20	Total audit hours	44
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Number of residents/patients interviewed	6	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents'/patients' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	10	Number of relatives interviewed	2
Number of residents'/patients' records reviewed using tracer methodology	3			Number of GPs interviewed (Residential Disability providers only)	1

Declaration

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

I confirm that:

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

Dated Friday, 7 March 2014

Executive Summary of Audit

General Overview

Alexander Lodge Rest Home is a 23 bed facility located in South Auckland and provides rest home level care. At the time of audit there are 17 residents receiving care, and one boarder. Four of the residents are aged under 65 years of age. The owner purchased this rest home in April 2013 and works on site most days. There have been no changes to the services, building or environment since the last audit with the exception of an ongoing refurbishment programme and replacement of some equipment and furnishings. Monitoring of the quality and risk programme is overseen by an independent quality adviser. An experienced registered nurse provides nursing services. At this audit there were no areas identified as requiring improvement.

Outcome 1.1: Consumer Rights

Alexander Lodge Rest Home implement processes that demonstrate their commitment to ensuring residents' rights are respected during service delivery. As observed, staff knowledge and understanding of residents' right is embedded into everyday practice. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) clearly displayed at the facility.

Residents are provided with care and services that allow them to maximise their independence and to ensure their needs are met. Resident and family interviews confirm their satisfaction with the staff and provision of services. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

There is a Maori Health Plan in place that identifies how the service responds to residents who identify as Maori. Currently there are no residents who identify as Maori. Recognition and respect for all individual's cultural, values and beliefs is well managed by the service and clearly documented during the assessment and care planning process.

Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice with specialist input as is appropriate. Documentation and interviews confirm there is effective and honest communication between service providers, other health professionals, such as mental health services, residents and family. Residents have visitors of their choice and are actively encouraged to maintain links with family, friends and community.

The right to make a complaint was well understood by residents and family members interviewed as well as staff and the owner/manager. There have been no complaints received since the owner purchased the facility.

Outcome 1.2: Organisational Management

The owner purchased Alexander Lodge Rest Home in April 2013 and is supported by an experienced registered nurse (RN) who has worked in this rest home since 2008. Both the owner/manager and the RN participate in relevant ongoing education. The Alexander Lodge Rest Home business plan and quality and risk plan provide the framework for all services provided. The vision, mission and goals of the rest home are clearly documented. Many of the goals for 2013 related to facility refurbishment or replacement of equipment. These goals are noted to be met.

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Current accepted human resource processes are implemented, including prospective employees completing an application form. Interviews are conducted and reference checks obtained. Staff are provided with an employment contract and job description. Where staff or contractors are required to have an annual practising certificate (APC), these are monitored and all are current.

New staff complete an orientation programme. Staff participate in regular on-going education. Staffing numbers meets the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB). There is a staff member on duty at all times with a current first aid certificate.

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

Outcome 1.3: Continuum of Service Delivery

The service maintains documented entry criteria and there are processes in place should a resident be declined service. At the time of audit the service has not declined entry where the resident has an appropriate assessment and a bed is available.

Residents receive timely, competent and appropriate services in order to meet identified goals. Assessment, care planning, review and

evaluation of care show how outcomes are achieved via multidisciplinary teams. Resident and family input into planned care is well documented. Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

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Residents receive medicines in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements, including cultural and personal likes and dislikes.

Outcome 1.4: Safe and Appropriate Environment

Alexander Lodge Rest Home has 19 single occupancy rooms and two share twin occupancy rooms. Sixteen of the resident rooms are located on the ground floor, with five residents' rooms, including the two share twin rooms, being located on the first floor. There are processes implemented to ensure residents who are living on the first floor are independently mobile. An elevator is also present between the ground and first floor for use if required. There are sufficient toilets and showers for residents.

The laundry and garage is located in the basement and are accessible to staff only. The building has a current building warrant of fitness. Clinical equipment has evidence of current performance monitoring. Electrical equipment sighted did not initially have evidence of electrical safety checking. This was addressed by an external contractor during audit. Over the last year some improvements have been made in the facility with some rooms and corridors painted and new equipment purchased.

There is an approved fire evacuation plan and staff are trained in emergency and fire evacuation procedures. There are adequate supplies and equipment available and designated for use in an emergency. There is a staff member with a current first aid certificate on duty at all times.

Staff dispose of waste and hazardous substances in accordance with the organisation's policies. Chemicals are stored in a locked cupboard.

Residents and family members interviewed confirm the building is appropriately clean, ventilated and warm. There is a separate dining room and lounge area on the ground floor and a lounge area on the first floor. External areas are accessible to all residents and family members, including those requiring the use of mobility devices. There is an outside designated smoking area.

Outcome 2: Restraint Minimisation and Safe Practice

The service has policies and procedures in place that identify safe restraint minimisation practices. Currently there are no restraints or enablers in use. Staff receive appropriate education and can verbalise the processes to be undertaken should restraint be required. Enablers are clearly described as the least restrictive option to ensure resident safety.

Outcome 3: Infection Prevention and Control

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the registered nurse who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Residents are offered annual influenza vaccinations (with prior consent). There have been no reported outbreaks of infections at this facility in the last year.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	0	0	0	0	0
Criteria	0	114	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	4	0	5
Criteria	0	0	0	0	0	19	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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.

Attainment and Risk:FA

Evidence:

As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering resident bedrooms, use residents' preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (five of five staff from across the service) confirm they respect the resident's right to refuse cares or interventions. Staff can verbalise and were observed dealing with situations that arise which ensure residents' rights are maintained. This is confirmed during interviews with six of six residents (which include two under the age of 65 years and two residents who have active mental health service input) and two of two family members.

The Age Related Residential Aged Care (ARRC) requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

Attainment and Risk:FA

Evidence:

Document review: The resident's rights policy includes specific reference to the 10 rights that all residents have. The 10 rights are detailed. The policy notes:
- on commencement of employment all staff receive induction orientation training regarding Residents Rights and their implementation. (Follow up training is ongoing.)

- the Code of Resident's Rights is displayed and available to all residents and monitored to ensure the rights of residents are respected.
- new Residents are given a copy of the Code of Rights on admission and a copy is displayed on the wall in full view for Residents, caregivers and visitors.
- new Residents are also given a complaints form on admission with an explanation how this works.
- the Code is monitored through the implementation of resident and relative satisfaction audit.
- breaches of resident rights and responsibilities are to be brought to the attention of management in order for these to be resolved, causes identified and effective systems implemented to prevent recurrence. This should be done in conjunction with the Complaints Procedure and the Advocacy Policy.
- residents rights must always be considered when delivering, planning and evaluating care at all levels.

The policy includes a guide to the code is resident appropriate language and the contact phone numbers of the H&DC and the Advocacy services.

Stage two: Opportunities are provided for explanations, discussion, and clarification about the Code of Health and Disability Services Consumers' Rights (the Code) with the resident and family/whānau as part of the admission process. As observed, contact information for the Nationwide Health and Disability Advocacy Service is contained in the information given to residents during admission and the Code is displayed on both floors of the facility. Interviews with six of six residents and two of two family members report they are informed of their rights and that staff always respect all aspects of their rights. This is supported by interviews with the GP, one social worker from Middlemore Hospital and one key worker/social worker from Mental Health Services for Older People (MHSOP) both visiting from Counties Manukau District Health Board (CMDHB).

ARRC requirements are met.

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

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

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

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.

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The independence and individuality policy notes the organisation's philosophy to maximise the resident's independence and promote personal individuality. This is defined and guidance is provided for staff on how this can be attained. The importance of resident participation, choice and consent is detailed.

The sexuality and intimacy policy has a defined policy statements including to:

- ensure that the resident's dignity, confidentiality, and privacy is maintained at all times.
- people with impaired judgement are unable to make a distinction between what is appropriate and what is not.
- need for intimate contact does not change because of a dementing illness.
- where appropriate the resident can have a relationship and express intimacy.
- issues around intimacy and sexuality are appropriately managed ensuring resident's rights are protected but the rights of other residents and staff are not compromised.

Specific needs are assessed during admission assessment and documented on care plan which is to be evaluated at least every 6 months or earlier if needed.

Stage two: The environment allows residents physical, visual, auditory and personal privacy. There are two bedrooms with two beds; only one of these rooms is currently occupied by residents. The two residents have chosen to share the bedroom as they knew each other prior to entry to the facility. The bedrooms have appropriate partitions to allow visual privacy and as confirmed by the owner/manager and the RN there are office areas which can be used for discussions of a private nature as required.

Resident's needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in five of five resident file reviews which identify interventions put in place to match identified needs. Examples include residents who identify as Hindu having religious icons in their bedrooms and it is clearly described in care plans that they pray twice a day and the times they do this. The service ensures residents' religious beliefs are met. This is confirmed during resident and family interviews. One resident stated that if it is raining a staff member drives them to Friday church services.

Resident services are provided in a manner that maximises each resident's independence and allows choices to be respected. Examples are documented in five of five care plan reviews and identified during interview with six of six residents and the RN. These include educating residents who are able to go out independently the process of notifying staff of where they are going and their due time of return, trips to community groups and outings with friends and family. Care plans clearly show each residents level of dependence. Residents assist with general household chores, such as setting tables and watering the garden as they choose and are able to do safely. This is confirmed during six of six resident interviews.

Residents and family report that they are treated with respect and that resident's receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. This finding is confirmed during five of five staff interviews and the sighted responses from the resident satisfaction survey results.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.1.3.6 (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.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: 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.

Attainment and Risk:FA

Evidence:

Document review: The cultural safety policy identifies the manager and/or registered nurse (RN) will determine the cultural and/or spiritual needs of the resident in consultation with the resident, family and significant others as part of the admission process. Specific health issues and food preferences are identified on admission. A commitment to the Treaty of Waitangi is explicitly stated. The resident and /or family are consulted regarding the cultural/spiritual protocols to be observed in the provision of care and service. As required, a person acceptable to the resident shall be sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident. As appropriate, the services of a Kuia, Kaumatua or other culturally appropriate person shall be sought to act as advocate and support person for the resident and facility. Advice will be sought from the resident and/or family regarding a suitable person. In the event the resident and/or family are unable to provide advice, a leader of the appropriate Iwi/community will be requested to assist in this matter. (Refer to regional hospital for a current list of Iwi/community leaders). Guidance is provided or staff on the provision of culturally appropriate care. The importance of Whanau involvement in care is included.

There is a specific assessment which is undertaken to identify the care needs of Maori residents. Key documents including COR and privacy statements are available in Maori.

Stage two: The RN confirms that currently there are three residents of Maori descent who do not wish to be identified as Maori. There are no residents who identify as Maori. The owner/manager reports that there are no known barriers to Maori accessing the service. The service has links with the local Health and Disability Advocacy service and a Maori advocate details is available to staff and residents if required. The RN reports that residents who are Maori have tribal affiliation and contact numbers shown on their care plan as per information provided by whānau members. All residents' are informed as part of the admission process that they can bring an advocate with them at any time.

The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with the RN and two of two caregivers and the activities coordinator/caregiver. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents.

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Criterion 1.1.4.7 (HDS(C)S.2008:1.1.4.7)

The service provides education and support for tangata whaiora, whānau, hapu, and iwi to promote Māori mental well-being.

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

Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5)

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk:FA

Evidence:

Document review: The cultural responsiveness- other cultures policy noted all resident's cultural needs will be identified on admission and all reasonable steps will be taken to meet those needs and guidelines will be documented in resident's care plan. Families, and if appropriate, cultural leaders, will be consulted to identify cultural values and beliefs of the culture. Interpreters will be accessed if and when necessary (via the DHB) Staff can be used as translators for simple day to day communications. Respect of all staff for cultural beliefs will be enhanced through education of cultural values in the in-service education programme. Compliance will be audited through resident and relative satisfaction measurement

Stage two: Currently there is one resident who identifies as Pacific Island. (They were not able to be interviewed during the audit). The RN and two other staff members identify as Pacific Island and the service has effective relationships with community Pacific support groups. The RN has in-depth knowledge of Tikanga practices such as decisions related to care planning needing to involve and be discussed by all members of the family. (The word whanau is not recognised by all Pacific Island groups only the word family). The resident's care plan identifies care needs including having fried green banana as part of the staple diet. Interviews with three of three caregivers identify their knowledge and understanding of Pacific Island culture including specific festivals which are celebrated by the service to respect the resident's needs.

Currently there is no need for mental health services for Pacific Island residents but the RN reports that 'The Cottage' offers specific Faleola Services as required. (This service is attached to CMDHB).

Criterion 1.1.5.1 (HDS(C)S.2008:1.1.5.1)

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:

- (a) Developing effective relationships with Pacific people to support active participation across all levels;
- (b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
- (c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
- (d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.

This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

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

Criterion 1.1.5.2 (HDS(C)S.2008:1.1.5.2)

The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The spirituality policy provides guidance for staff on how resident spirituality needs can be met. Spirituality is noted not to be religion and identifies: The resident's individual values and beliefs are recorded on admission and taken in account when developing the care plan. Staff are required to provide services in a non-discriminatory way.

Stage two: Interviews with six of six residents and two of two family members confirm they are consulted on their relative's individual values and beliefs and that care is planned and delivered to meet identified needs. This covers social, spiritual, cultural and recreational needs. Family are encouraged to be involved in the development and review of the care plan (as sighted in five of five resident file reviews). One Samoan and five Indian residents have their cultural needs clearly stated on their care plans and it includes food likes and types, fluid preferences, religious needs and social activities to include cultural recognition. Of the five residents who identify as Indian, three are Hindu and two are Christian and this is clearly identified on their respective care plans. This is confirmed during interview with one Hindu and one Christian resident with the assistance of a staff member as interpreter. (Both residents can speak English but it was their decision to have an Indian speaker present at the interviews). One Indian family member confirms all their relative's cultural beliefs and values are met by the service.

The ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The 'code of ethics' document details the commitment to meeting the requirements of the 'association'. Other policy documents sighted identifies that residents have the right to care that is without discrimination, prejudice or bias.

Stage two: Staff employment processes include making staff aware of a code of conduct that covers working within professional boundaries and that staff refrain from acts or behaviours which could be deemed as discriminatory.

Interviews with five of five staff, six of six residents, two of two family members, two visiting mental health specialists and the GP confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. This is supported by the results of the resident satisfaction survey results sighted. Staff acknowledge the resident's right to say no or to refuse treatment or care. This is documented in one resident file related to declining attendance at an outpatient appointment. The requirements of specific mental health standard requirements are met and the service has a good working relationship with appropriate cultural support and advocacy groups who monitor resident satisfaction on a regular basis.

Criterion 1.1.7.2 (HDS(C)S.2008:1.1.7.2)

Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

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

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

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

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

Criterion 1.1.7.4 (HDS(C)S.2008:1.1.7.4)

The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

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

Criterion 1.1.7.5 (HDS(C)S.2008:1.1.7.5)

The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

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

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

Consumers receive services of an appropriate standard.

Attainment and Risk:FA

Evidence:

Interviews with five of five staff confirm that the environment in which they work encourages good practice. All staff have access to evidence based policies and procedures. Appropriate ongoing education and support services and persons, such as the gerontology nurse specialist (GNS) from Auckland District Health Board (ADHB), mental health team specialists for ongoing and crisis management from CMDHB and the GP are available to staff. Established links with other local health service are well documented and identified in resident notes and shown as part of care planning as process. DHB care guidelines are utilised as appropriate, such as continence management, abnormality of observations and when results should be reported.

Interviews with six of six residents and two of two family members confirm their satisfaction with all care delivery and staff attitude. This is further supported by the results of the resident satisfaction survey.

ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The open disclosure policy identifies open disclosure is a frank discussion with a resident and their support person about any adverse event when the resident has suffered any unintended harm whilst receiving care or an error that affected the resident's care but does not appear to have caused harm. The principals and process are detailed to provide guidance for staff. Refer to 1.1.4 re process to access to interpreters.

Stage two: Policy related to open disclosure is implemented by the service. Interviews with two of two family members confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family notification is clearly documented in four of the five document reviews undertaken. One resident does not which family to be informed. The service encourages residents and family to be fully involved in the care planning process as appropriate.

The GP and a visiting social worker/key worker confirm there is appropriate communication between all services involved in the resident care.

Wherever necessary and reasonably practicable, interpreter services are provided. The RN confirms that currently there are staff and family members who are able to act as interpreters for residents. Interpreter services are always used as required when residents attend off site health or community services to ensure they have a complete understanding of what is said. This is confirmed in documented letters from outpatient appointments sighted in residents' files.

ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.10: 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.

Attainment and Risk:FA

Evidence:

Document review: The resuscitation policy and protocol (December 2014) details only competent persons can make decisions about resuscitation. The policy notes a GP can give advice about the clinical appropriateness of resuscitating their patient. This is, in essence, treatment planning. At the outset, resuscitation is a medical issue for the doctor responsible for the patient's care. Resuscitation is generally not clinically indicated where CPR is considered futile or medically contraindicated. If in doubt, resuscitate'.

The policy notes resident rights to refuse treatment and not to be subject to experimentation. Advanced directives decisions are at be reviewed at least every two years.

The policy notes residents or designated representatives will be asked to sign a general consent for the collection and storage of information, release of information, photographs, outings and general indemnity. Specific consents will be obtained as required. There is a separate consent for the withdrawal of

consent for care or treatment.

Stage two: A specific signed consent form and resuscitation instructions signed by the resident is sighted in five of five resident file reviews. This includes GP assessment to say the resident is deemed able to make appropriate decisions. Interviews with six of six residents and two of two family members confirm informed consent is discussed as part of the admission process. The RN and three of three caregivers verbalise their understanding of acting on valid advance directives.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Five of five resident file reviews and interviews with six of six residents and two of two family members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family is encouraged to involve themselves as advocates as appropriate. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and staff interviews confirm the right of residents to nominate who they wish to advocate on their behalf at any time. The resident's decision is respected by the service. This is confirmed by the key worker/social worker during interview.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has unrestricted visiting hours. Interviews with six of six residents confirm they have access to visitors of their choice. Two of two family member interviews confirm that they are always made to feel welcome and that they have unrestricted access to the owner/manager.</p> <p>Residents are encouraged and supported to maintain and access community services along with friends and family members. This includes appropriate cultural support groups such as 'The Cottage' community mental health services. Documentation sighted in five of five resident files identifies that regular community contact is maintained with support groups such as Communicare, and local church groups. Residents, who are able, go out shopping independently to local shops and/or with family as they wish. There are regular visits from community groups and mental health support services as appropriate. One resident (who is under the age of 65 years) attends a regular community support group and has gained documented certificates for all courses completed.</p>

On the days of audit residents were seen coming and going as they wish and they visit community services independently. One resident stated they attend a local church service every Friday.

ARRC requirements are met.

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

Attainment and Risk:FA

Evidence:

Document review: There is a complaints policy (November 2013) which details the residents right to make a complaint. How complaints are to be documented, communicated, investigated and followed up is detailed. Timeframes for responding to the complaints is detailed and meets the H&DC code. Complaints can be documented on a complaints and compliments form.

Stage two:

Interview with the owner/manager, RN and two of two care givers confirm an understanding of the roles and responsibilities in relation to complaints reporting and management.

Information on the right to complaint and the process is provided to new residents during the admission process. This is verified during interview with the RN, and residents and family members interviewed.

Complaints forms are available for residents and family members at the front entrance to the facility without having to be requested.

A complaints register is maintained. The owner manager and independent quality adviser state there have been no complaints received since the last certification audit from residents, family members, the District Health Board (DHB), the Ministry of Health (MOH) or Health and Disability Commission (H&DC).

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.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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.

Attainment and Risk:FA

Evidence:

Document review: The business plan, quality and risk management plan (September 2013) details the organisation's mission statement: to provide a quality, homely environment in which the frail elderly and/or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed. The rest home philosophy is detailed and includes a continual improvement focus. This

includes assisting those who are independent to continue to be as independent as possible, and providing individualised and culturally appropriate care. Meeting legislative requirements and providing care in accordance with good practice are included. There are nine documented goals/objectives. This plan is required to be reviewed at least annually.

The good employer policy states the manager will be available during office hours and on call 24 hours a day. The manager holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to the aged care sector. The role of the manager is detailed

Stage 2: The owner manager advises the annual review of achievements against the quality and risk objectives are used as a component of reviewing how services are being provided and what changes may be required/recommended. There are no changes proposed to the vision, values at this time. Objectives/goals for 2014 are documented and are monitored and identified when completed/implemented in records sighted.

The curriculum vitae (CV) of the owner/manager sighted at audit notes the manager holds an "Diploma in Telecommunications' in Fiji and a Bachelor of Engineering Electronics and Communication' completed in India. The owner/manager worked in telecommunications and process control services for a power company in Auckland in a management role. The owner manager has attended more than eight hours of education relevant to managing an aged residential care facility in the last 10 months including: advance care planning (April 2013), falls prevention (April 2013), human resource management (15 April 2013), an aged care service professional development seminar (12 June 2013), first aid certificate (17 November 2013), safe food handling (January 2014), safe handling of chemicals (February 2014) - Certificates of attendance sighted.

The owner/manager confirms being on call when not on site and is contacted when staff call in sick, or if there are any facility related issues.

The RN is responsible for clinical care provided. The RN holds a current annual practising certificate (APC) which is sighted at audit. The RN is rostered on site at least five days a week and is contracted for a minimum of 20 hours a week, although works more hours than this. The RN lives in close proximity to the rest home and attends any afterhours events where required including those on the behalf of the owner/manager. A job description is present in the RN file detailing the RN roles and responsibilities. The RN participates in relevant ongoing education including:

- starting out in infection prevention and control – 15 February 2011 (independent infection control consultant)
- infection prevention and control study day – 15 August 2013 (ADHB)
- clinical assessment study day September 2013 (ADHB) - 18 hours education
- chemicals safety training – 13 February 2014 (chemical supplier)
- resuscitation level four certificate - 3 May 2012 (ADHB)

The RN has completed the professional development and recognition requirements for a 'staff nurse – level three' and letter verifying this sighted dated 24 October 2012. The RN's next scheduled portfolio assessment date is August 2015.

There is an external quality adviser (EQA) who is contracted to work six hours a week on site. (Refer to 1.2.3).

The ARRC contract requirements are met.

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

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

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

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

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

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

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.

Attainment and Risk:FA

Evidence:

The owner manager advises the RN is second in charge in the owner manager's absence. The RN has been working in this rest home since September 2008 and is very familiar with the facility, residents and policies/procedures. This is confirmed by the RN during audit. The RN is able to identify her responsibilities in the manager's absence. This includes ensuring appropriate staffing, clinical and other supplies are available and that the day to day care needs of residents are met in a timely manner.

Two of two caregivers interviewed verify the RN is in charge in the owner manager's absence. The staff confirms the RN is contactable when required.

The ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The health and safety policy requires the reporting of all unsafe acts, incidents and near miss events. Definitions are included including hazards, significant hazards. There are nine stated objectives for this policy. All reported events are required to be investigated and corrective actions implemented as required. Hazards and potential hazards are to be identified and managed. The responsibilities of management, contractors, staff and visitors are included. Injury prevention is promoted. The process for managing staff exposures to contaminated sharps is included.

The organisation's business, quality, risk and management plan (September 2013) identifies a focus on continuous quality improvement. The programme includes ensuring:

- policies and procedures are up to date
- staff are appropriately trained
- ensuring culturally appropriate care is provided
- internal audits are used to review processes and provide early detection of problems
- all infections are reported and evaluated
- incidents and accidents are reported and evaluated with an improvement focus
- use of restraints avoided
- resident and family involvement in care is sought
- risk management processes are identified in the quality and risk plan (September 2013).

The quality and risk plan (September 2013) identifies goals and objectives, management controls and who is responsible. This document details the process/cycle to be used for corrective action planning. The risk management programme includes identification of risks, objectives and management controls and who is responsible and how the risk will be measured.

The quality and risk plan includes the processes required in corrective action planning. This includes evaluation of the effectiveness of any initiative and communication with staff/residents and other relevant stakeholders.

Stage two: Two of two caregivers, the RN and the owner manager are able to identify their responsibilities in relation to implementing the quality and risk programme. They are assisted by an independent quality adviser (QA) who comes on site one day a week. The QA advises she assists with reviewing and updating policies and procedures and document control processes. Policy manuals are sighted to have been reviewed by the QA in January 2014 and the front of the manuals signed to verify this has occurred. The January 2014 minutes of the staff meeting note changes have been made to four policies and these policies are identified. A copy of policies and procedures are available for staff in the staff office (sighted).

Staff confirm they are well informed of quality and risk related activities as the number and type of incidents and trends, residents with infections, use of

restraints and enablers, audit results, staff education programme, satisfaction survey results, changes in policies and procedures and individual resident care needs are discussed at the monthly staff meeting. The minutes of the last three meetings are sighted at audit.

An annual review of achievements in relation to the 2013 quality and risk plan are sighted. The review was undertaken by the QA and notes all scheduled audits have been completed. A summary of the key audit outcomes and areas requiring improvement are noted. All staff training provided as scheduled/planned. There have been no complaints received in 2013.

A review of the results of eight audits completed in 2013 was sighted. This includes: cleaning service audit (April 2013); infection prevention and control and hand washing audit (August 2013); staff satisfaction audit (October 2013); non restraint audit (October 2013); staff file audit (October 2013); code of rights audit (October 2013); complaints audit (October 2013); and staff education audit (December 2013). Overall there is a high level of compliance with the organisation's policy and procedure requirements. Where improvements are required these are documented, communicated and implemented.

A resident satisfaction survey is underway during audit. The owner manager advises it is difficult getting participation in the survey and at audit only three responses have been received and these are sighted. The owner manager is working to find ways to assist residents and family members to have improved contact opportunities. A monthly 'happy hour' has been commenced.

A hazard register is sighted dated January 2014. This register lists hazards per area of the rest home, identifies the hazard rating, mitigation strategies and monitoring processes. A new hazard form sighted for a broken toilet seat. This hazard has since been addressed. The quality and risk programme sighted includes a range of resident related risks, environmental risks, certification and compliance risks, pandemic related risks, accident and incident related risks, loss of key staff, succession planning and natural disasters (sighted) and loss of documentation / electronic data. Fraud / theft, natural disasters and personal grievance are also noted as risks factors.

ARRC contract requirements are met.

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

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

Attainment and Risk:FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.6 (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.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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.

Attainment and Risk: FA
Evidence: <p>Document review: The incident policy identifies the following type of events are to be reported: anything that makes a resident unhealthy or unhappy; when personal injury occurs (i.e. skin tears, infections, falls, fractures) and any incidence of abuse and/or neglect; and any event occurs which creates risk or potential harm or injury. There is a template form for the reporting and investigating of incidents/accidents.</p> <p>Incidents must be reported to enable management to enable timely investigation and corrective actions undertaken.</p> <p>The health and safety policy details the requirements for essential notification including to the department of Business, Innovation and Employment. A form is also provided for the notification of uncontrollable events as per the aged related care contract (ARRC) requirements. Another policy details the process for managing the unexpected death of a resident. This includes notification to the Police/Coroner. The notifiable disease policy details the process for reporting notifiable diseases.</p>

Stage two: Two of two caregivers interviewed are able to describe the type of events which are to be reported along with the reporting process. The staff advise they are provided with current information on incidents as a component of shift handover. Monthly summary of the number, category and trends and discussed at the monthly staff meetings. This is verified in the staff meeting minutes sighted at audit.

The owner/manager and RN are able to detail the type of events which are required to be reported as an essential notification and advise there have been no such events since the last audit.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5)

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk:FA

Evidence:

The RN interviewed advises that the initial histories are obtained in consultation with the resident and next of kin. The RN advises that the care plans are developed in conjunction with the resident and family. Residents and next of kin are advised by the RN or caregivers of incidents. The RN also informs the family of changes in the resident's condition including improvements. This communication is verified during interview with family members and review of sampled residents' files. The owner manager advises 'happy hours' have been commenced and family are invited. This is to provide additional opportunities for residents and family members to have interaction.

The RN advises any concerns about residents will be notified to the GP and where relevant the mental health services including via the crisis team if this is applicable. Support networks would be accessed via the mental health services where this is required. The resident under the care of the mental health service is visited monthly by the resident's allocated key worker. The key worker interviewed advises 'wellness' supports are available.

There is a reference to the community mental health crisis plan in the resident's file. The resident attends a weekly 'well women's' group – 'Whaiki' and feels well supported as confirmed in interviewed with the resident. Certificates of completion elements of the programme are framed and on the wall displayed in the resident's bedroom. This includes cooking, gardening and self-esteem.

Criterion 1.2.5.1 (HDS(C)S.2008:1.2.5.1)

The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

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

Criterion 1.2.5.3 (HDS(C)S.2008:1.2.5.3)

The service assists with training and support for consumers and service providers to maximise consumer participation in the service.

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

Criterion 1.2.5.4 (HDS(C)S.2008:1.2.5.4)

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.

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

Criterion 1.2.5.5 (HDS(C)S.2008:1.2.5.5)

The service implements processes that involve consumers at all levels of service delivery.

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

Standard 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk:FA

Evidence:

There is a 'family participation' policy that identifies the organisation actively promotes, encourages and supports the participation of residents, family members and or carers in the planning, implementation and evaluation of services including mental health. The policy is dated March 2013. The policy notes that the manager has an open door policy and promotes a partnership philosophy with organisations and service providers to ensure continuity of care.

Family members interviewed confirm they are kept well informed of the resident's needs and are involved in service planning.

A family advisory committee is not in place. This is not applicable to the service setting. Resident meetings occur. The most recent meeting occurred on 4 February 2014 and minutes of the meeting sighted. The owner/manager advises family members are welcome to attend but currently do not do so.

Criterion 1.2.6.1 (HDS(C)S.2008:1.2.6.1)

The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.

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

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

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

Attainment and Risk: FA
Evidence: <p>Current annual practising certificates are on file for the RN, GP, podiatrist, and pharmacist.</p> <p>Recruitment processes include completing a job application, conducting an interview, and reference checking. These are present in the staff file of the employee who commenced work in 2013. Signed employment agreements and job descriptions are on file for the five staff whose file reviewed during audit including the four staff whose employment transferred from the previous owner.</p> <p>Staff are required to complete an orientation programme which includes an orientation to the facility, policies and procedures, emergency management, security, fire safety, staff responsibilities, the Code, documentation requirements, and individual resident needs. The two caregivers during interview advise new employees are supernumerary and buddied with a senior caregiver for each shift. The staff confirms the orientation prepares new staff for their role. Ongoing support is provided as required. Records evidencing staff are completing the requirements of the orientation programme sighted in all staff files sampled.</p> <p>There is an education plan which details education required to meet the requirements of the HDSS Standards, ARRC contract and legislative requirements over a two year period. Records of attendance are kept and sighted including for chemical safety (February 2014); health and safety/security and civil</p>

defence (September 2013); infection prevention and control/outbreak management (July 2013); restraint minimisation/managing challenging behaviour (September 2013); and first aid (August 2013). The two caregivers and the RN interviewed confirm they have access to relevant ongoing education.

ARRC contract requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The good employer policy identifies the RN and the manager is always on call. The staffing level and skill mix policy notes the manager, or delegated person, has discretion to extend hours and staff numbers to respond in certain situations (i.e. special events, emergencies, resident acuity issues, infection outbreaks). The staffing level reflects: number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience. An appropriate skill mix is reflected on the roster. The manager is responsible to ensure that each shift is filled by a staff member with the appropriate experience and skills. Junior staff will always be supervised by a senior staff member and not work by themselves until deemed competent. Staff working in senior positions have the necessary qualifications and competence to do so. Staff levels reflect resident's assessed needs.

The policy notes there will be at least one staff member on duty at all times if there are less than 10 residents. There will be at least 2 staff members on (one on duty and one on call) if there are more than 10 residents.

Stage two: The roster sighted verifies there is a minimum of one staff member on duty at all times. Two caregivers are roster for peak periods in the morning and the afternoon shift. There are designated hours for activities. There is a staff member on duty with a current first aid certificate and medication competency and records sighted.

Interview with the owner/manager, RN and two of two caregivers confirms the RN is on site Monday to Friday and on call when not onsite. Staff advise the RN is readily contactable and comes when needed. The owner is on site seven days a week and typically for between 8 to 12 hours a day. Staff advise the owner/manager assists with cleaning, laundry services and cooking as required. The owner/manager also answers the phone and provides support to care staff. Staff confirm the manager as having a very 'active' role in the facility. The two caregivers advise the staff hours are sufficient to meet the care needs of the residents.

ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

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

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.

Attainment and Risk: FA
Evidence: <p>Information sighted in five of five resident file reviews shows that information management systems are implemented to meet policy requirements that ensure entries are accurate, timely and appropriate to interventions shown in residents' care plans. All records clearly show the staff member's name and designation in a legible manner. Staff enter information into resident progress notes every shift. All information is integrated in one file. Resident information is stored securely and is not publicly accessible or observable to the public.</p> <p>ARRC requirements are met.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

Attainment and Risk: FA
Evidence: <p>The service provides rest home level care and residential disability psychiatric care. The entry criteria, assessment and entry process is clearly documented and communicated to the potential resident and family as confirmed during resident and family interviews. Two of two family members confirm all information was explained and factual when they made enquiries and during the admission process.</p> <p>Information about the service is available on the internet and in hardcopy. The service has a good working relationship with the local referral agencies who are aware of the service level offered. The RN explained that on some occasions residents are referred to the service who need a different level of care, such as secure care or hospital level care and information is given to the person making the request related to other appropriate services. If a resident requires a</p>

different level of care they are reassessed by and independent agency. There is evidence of this process in one set of resident notes reviewed and no decision for placement has yet been made following the review process.

ARRC requirements are met

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

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

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

Criterion 1.3.1.5 (HDS(C)S.2008:1.3.1.5)

To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

The RN reports that no residents who meet the entry criteria have been declined if a bed is available. She reports that if a resident was to be declined entry other options or alternative service information would be offered to the applicant or their family.

The admission agreement is based on the NZ Aged Care Association Agreement. The sighted admission agreement contains information on the termination of the agreement. The admission agreement describes if the residents needs change and the service can no longer provide safe hospital level of care to meet the needs of the residents.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: the RN responsibilities includes (but is not limited to) the following:

- care planning and training:
- the development of the (initial) nursing care plan on day of admission
- the completion of the admission assessment on day of admission
- the completion of all compulsory assessments within 1 week of admission.
- the completion of all other assessment tools as required, eg continence, pain and wound, Waterlow, Coombes, within 2 weeks of admission
- the coordination and documentation of a comprehensive Care Plan within 3 weeks
- ensuring that the Care Plan reflects the assessments and the recommendation of other health professionals where their input is required
- on-going re-assessment and review of Care Plans through review of all relevant assessment tools prior to updating care plan
- ensuring GP assesses residents within 2 working days of admission
- ensuring GP 3 monthly/monthly and pm treatment and medication reviews of residents.

Stage two: Each stage of service provision (assessment, planning, oversight of provision of care, evaluation and review) is undertaken by a RN who is suitably qualified and experienced to perform the role. Residents who have specialist mental health input have this identified in their care plan. (Confirmed in two of five file reviews). The main provision of care is provided by caregivers with oversight being undertaken by the RN who has a current nursing annual practising certificated (sighted).

The initial assessment covers the resident's medical condition and nursing assessments for activity, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behavioural, depression, pain, social history, level of independence, skin integrity, sexuality, spirituality, values and beliefs are completed. The care plan format identifies problems, goal and aims and interventions. Five of five resident file reviews confirm that all timeframes as shown in policy are met. The long term care plan is reviewed at least six monthly. The care plan format includes the physical, psycho-social, cultural and spiritual needs of the resident. All residents have an introductory profile page which introduces them, gives a short social history, shows likes and dislikes and then itemises cares on a care plan which is detailed and covers all aspects of care. Five of five file reviews identify that residents are assessed for entry as rest home level care.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Each shift has a verbal handover and there is a written handover sheet which identifies care requirements including any required changes. Each shift makes entries into resident progress notes to record care provided and any additional changes that may be required. Care review processes includes the resident, family, the pharmacist, GP, nursing staff and any other services who may be working with the resident.

Interviews with two caregivers, one RN and the GP confirms that they receive appropriate information to ensure all resident cares can be delivered in a manner to meet their identified needs. Staff report they work well as a team and that they are informed of individual resident needs. During interview, the GP reports that there is very good communication between himself and all staff to ensure excellent continuity of care.

Tracer one

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

Tracer two: A resident under the age of 65

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

Tracer three:

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

ARRC requirements are met.

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.

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

Criterion 1.3.3.3 (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.

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

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

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

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

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

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

Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

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

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

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

Attainment and Risk:FA

Evidence:

The service implements policies and procedures to ensure the use of appropriate assessment tools for all residents so that needs are ascertained and monitored. The tools sighted include continence, hygiene and personal grooming, Norton scale pressure area, falls (Coombes), pain, social activity, cultural/spiritual/values/beliefs, behaviour management and depression scale as required. The resident's needs, outcomes and goals are clearly identified during the assessment process and information is used to inform care planning processes. As the resident base is multicultural all assessments have a cultural component which is very well managed by the service. All processes are paper based and accessible to staff.

ARRC requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

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

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

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

Attainment and Risk: FA
Evidence: <p>Five of five resident file reviews identify that care planning interventions are individualised to reflect resident's assessed needs. Care planning is resident focused and identifies input from all health care workers involved in resident care, as well as the resident and family as is appropriate. Assessment processes inform care planning in a meaningful manner and triggers for anxiety and behaviours are shown. Three of the file reviews are undertaken which confirms specialist input as required, short term care planning for issues that are expected to last less than two weeks, such as infection management, the promotion of resident independence and cultural and spiritual consideration into all care provision. All interventions are detailed and include specific crisis plans for medical issues such as diabetic management and actions to take should a resident's mental status decompensate. Residents have one main folder that contains their medical information, nursing assessment, care plan, routine observations, activities, therapies, multidisciplinary reviews, correspondence including off site consultations.</p> <p>Staff interviews with two caregivers, one RN and the GP confirm the information ensures continuity of care. Interviews with six of six and two of two family member's report all care is provided to meet their needs by staff who are skilled to deal with varying situations.</p> <p>ARRC requirements are met.</p>

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

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

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

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

Service delivery plans demonstrate service integration.

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

Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.

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

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

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

Attainment and Risk: FA
Evidence: <p>The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. Five of five care plan reviews confirm care planning is individualised and personalised to cater for each residents assessed needs from all services involved. As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions.</p> <p>An interview with two of two caregivers confirms their knowledge and experience allows them to follow the instructions shown on resident care plans to ensure appropriate care for each resident. If an intervention is not working well it is reported to the RN who evaluates the resident's progress.</p> <p>Six of six residents and two of two family members confirm during interview that they are satisfied with the care and interventions provided by the service. Residents confirm they are included in all care decisions.</p> <p>ARRC requirements are met.</p>

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

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

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

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

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

Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;

- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;
- (e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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

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.

Attainment and Risk: FA
Evidence: <p>Five of five resident file reviews identify that each resident has a social and recreational assessment completed as part of the admission process. The activities coordinator has completed an annual activities plan but this is individualised on a daily basis to meet resident needs. There is pictorial evidence of many and varied activities including the celebration of religious and cultural festivals such as the Diwali festival where all staff dressed up in Indian costume for the day. Residents have a planned outing at least three weekly and they are assisted and encouraged to maintain family and community activities. Residents regularly attend community church services and Communicare activities. On-site activities include bingo, cards, outside entertainers, karaoke, news readings and one on one discussion. There is a raised garden full of edible produce which is managed by the residents and everyone had made themselves a personalised place mat which several residents showed the auditor on the days of audit. Residents' activities are meaningful and appropriate to match identified age, culture and wants. Activities are well resourced.</p> <p>Five of six residents confirm they are very happy with the activities offered. One resident said they would enjoy having access to a computer so they can email friends. This was raised at the time of audit with the owner/manager who will look into this.</p>

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Five of five resident file reviews identify that the interventions documented on care plans are evaluated at least six monthly to ensure residents goals, needs and wants are being fully addressed. Evaluations indicate the degree of achievement or response to supports and interventions that are in place. If the interventions are not working well they are changed and staff are informed. Resident and family input is shown in documentation sighted.</p> <p>Where progress is different from expected, the service responds by initiating changes to the care plan as sighted in five of five file reviews or by use of short term care planning interventions for temporary changes. This is sighted in two of the three care plans reviewed. Long term interventions are analysed, reviewed, discussed with the resident and family members as appropriate.</p> <p>Six of six residents and two of two family member interviews confirm services are delivered in a manner that meets all their needs.</p>

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

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

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

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

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

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

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

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

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

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

Attainment and Risk: FA
Evidence: Document review: The transfer, exit, discharge and transfer policy (November 2011) identifies referrals to specialist services are made by manager, or delegated person or GP (i.e., physiotherapist, occupational therapist, psychologist, speech therapist, Assessment Treatment and Rehabilitation Unit (A,T & R), dietician, naturopaths, Doctors, Podiatrist, District nursing, wound specialist, dentist, continence advisors, optometrist, specialist, social worker, public hospital and laboratory service). Stage two: Referrals are made to other health care service by the RN or GP as appropriate with resident approval. One file review identifies that the resident refused to attend a planned outpatient appointment at the general hospital. Staff respected the resident's wishes. This is confirmed in five of five file reviews and during six of six residents and two of two family member interviews. Other health service input sighted in residents' files includes general medicine, eye clinic, psychiatrists, outpatient appointments, cardiology, radiology, mental health, renal, surgical services, mental health services for the older person, community mental health services (The Cottage), immunology and dietitian services.

During interview the GP confirms that appropriate referrals to other health and disability services are well managed at the service.

ARRC requirements are met.

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.

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

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

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

Attainment and Risk: FA
Evidence: Document review: The transition, exit, discharge or transfer policy (November 2011) details four objectives: These are: - residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes in the diary - the family will be notified of the upcoming appointment and will be invited to attend and assist. - ensure that we facilitate a planned transition, exit, discharge or transfer in collaboration with the resident. - ensure that we identify, document and minimise risks associated with each transition, exit, discharge or transfer, including expressed concerns of the resident or their representative. - ensure that every effort is made the process is as un-disturbing as possible and undertaken with clarity, compassion and respect. The policies includes

guidance for staff on each component.

The transportation policy is aimed to ensure the vehicles used for transportation are appropriate, and the safety of staff and residents is maximised at all times.

The requirements for vehicles used to transport residents to appointments is detailed. If staff accompany a resident they are required to have a current first aid certificate and valid driver's licence.

Stage two: Risks are identified prior to planned discharges (confirmed by interview with the RN and two of two caregivers). There is open communication between the service and family members related to all aspects of care, including exit, discharge or transfer. If there are any additional specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision, required interventions, information profile page, current medicines which identifies known allergies and a summary of the reason for transfer.

ARRC requirements are met.

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

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

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

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.

Attainment and Risk:FA

Evidence:

Document review: Medicines management policy (January 2013) details process for storing, checking, administering and documenting medication administration. The process for assessing and recording allergies is noted. Residents can self-administer medications with the agreement of the GP/nurse practitioner. Medication errors are to be reported. Residents have the right to refuse medications. Daily checks of the minimum and maximum temperature of the refrigerator where medication is to be stored is to be undertaken and documented weekly. All Controlled Drugs are kept in a locked safe or locked cupboard accessible only to senior staff. Administration is recorded in a Controlled Drug Register to keep a running balance of stock. Nominated staff members sign all entries in the register. Keys to the medicines and Controlled Drugs rooms or cupboards are held by one senior staff member responsible for drug administration on each duty. Access to these areas is restricted to staff authorised to handle medicines. These persons have completed a medication competency. Nominated senior staff check all medicines for expiry dates and deterioration each month. Stock is appropriately rotated to ensure that oldest stock is used first. Expired and discontinued medicines is kept separate and in a secure area for return to the pharmacy for disposal.

Stage two: The service implements the medicine management process as per policy and procedures described in the document review. Policy covers resident self-administration of medicines. During interview with the RN it is confirmed that there are currently no residents who self-administer medications.

The Medico Pak system is used at the facility and documentation identifies each resident's medications are checked for accuracy upon arrival from the pharmacy. Medicines that are not packed, such as liquid medicines are individually supplied for each resident.

Medication is only administered by staff that have an approved competency. Competencies were sighted for one RN and five caregivers which covered oral, and insulin administration. Caregiver interviews, with staff that hold medicine competencies, confirm their knowledge and understanding of safe medicine practices.

The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly which he signs for on the resident medication chart as identified on 10 of 10 medicine chart reviews. Each individual medication is signed for by the GP including stop-start dates for short course medicines. The prescriptions, which are now pharmacy generated, are legible, record the name, dose, route, strength and times for administration. The change to pharmacy generated medicine charts commenced on the day of audit. Pharmacy monthly reconciliations of medicines are evident.

All medicines are stored in the locked medication cupboard. Controlled drugs are stored in a locked box kept in the medicine cupboard and are signed out by two staff when given. A weekly stock count is recorded in the controlled drug register. Sample signature verification is recorded for all staff who administer medicines.

The RN confirms all 'PRN' (as required) medications are closely monitored and if they are required on a regular basis, the GP will chart the PRN medication to regular medication as appropriate following assessment. Caregivers must contact the RN prior to the use of any PRN medication. During interview the GP confirmed requests for medication changes from specialist providers, such as mental health, are followed. This is confirmed during a review of three of five

residents' files who have mental health input. Blood tests are undertaken at regular intervals to monitor drug toxicity levels as appropriate and the frequency is identified on required drug charts and shown on the care plan.

All the medicine charts sighted identify resident allergies and have a current photograph of the resident for identification purposes. The service has standing orders in place which were updated on the day of audit and signed off by the GP to ensure they meet current legislative and best practice standards. Standing orders cover diarrhoeal medicines, indigestion liquid and paracetamol.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The food services dietary policy details process for identifying and communicating resident individual dietary needs and process for access dietitian when this is required. On admission resident dietary likes/dislikes, utensils, assistance required and cultural and medical requirements are identified and incorporated into the residents care plan. An annual food satisfaction survey is to be undertaken to ascertain satisfaction with food services.

The food handling and preparation and food hygiene document (January 2013) details food handling and food safety principals including related to defrosting, cooking, reheating and handling food.

Stage two: The current three weekly rotating menu is under review as confirmed by emails sighted. It was last reviewed in May 2010 by a registered dietitian. The cook confirms that the food and fluid needs of residents are all met by the service. Examples sighted include cultural needs and requests such as vegetarian diets for three residents who identify as Hindu and fried green bananas for a Samoan resident. The service celebrates birthdays and cultural festivals with appropriate additions to menus.

Interviews with six of six residents confirm they are very happy with the food service and that their likes and dislikes are catered for. Family members bring in food for relatives if they wish and this is confirmed during two of two interviews.

There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. The kitchen has an up to date risk register dated January 2014. Kitchen staff have completed food safety qualifications.

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The health and safety policy (October 2013) includes guidance for staff on storage of chemicals and requires safety sheets to be present for chemicals in use. The personal protective equipment (PPE) policy provides guidance for staff on when and how PPE should be appropriately used including gowns, gloves, masks, particulate mask, eye protection and impermeable gowns.

The sharps safety policy details how staff are to safely dispose of sharps. Sharps containers are to be stored safely and disposed on when three quarters full. The medical waste policy (January 2013) details how medical waste is to be disposed of including sharps, controlled waste, 'soft waste' and non-hazardous waste.

Stage two: Waste that may be contaminated or soiled with potential infectious body fluid is double bagged in general waste bags. Two of two caregivers interviewed verify that used incontinence pads are disposed of in this manner. All waste that is not controlled or hazardous (i.e. general waste, household recyclable) is discarded through the normal rubbish collection and recycle process.

There is adequate supplies of personal protective equipment present at audit, including gloves, masks, aprons and eye protection. Staff are observed to be wearing PPE appropriately during audit. The two caregivers interviewed can identify when PPE is required to be worn.

Material safety sheets are available on site for two chemicals selected at random for review (sighted).

ARRC contract requirements are met.

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

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

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

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

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

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

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

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

Attainment and Risk:FA

Evidence:

The building has a current building warrant of fitness dated as expiring 9 February 2015 (sighted). Electrical appliances did not evidence current electrical test and tagging. The owner manager contracted an external contractor who attended the second day of audit and completed test and tagging of electrical appliances. The owner manager has replaced a significant number of appliances since purchasing the business in 2013.

The elevator which goes from the ground floor to the first floor has been assessed recently and meets required standards. The RN and owner manager advise only residents who are independently mobile are allocated rooms on the first floor of the rest home.

Clinical equipment including scales, tympanic thermometer and sphygmometer have undergone performance monitoring tests in March 2013. They are scheduled for re testing in March 2014.

Hot water temperatures of four resident rooms selected on a rotating basis are being monitored each month. The last four months records sighted demonstrate all recorded temperatures are at or under 45 degrees Celsius. At audit a check of the temperature of three residents' room hand basins verifies the hot water is within required parameters.

There are handrails present in the corridors and stairwell up to the first floor. Grab bars are present in the toilet and shower areas (sighted). The floor surfaces are flat or have a visible gradient. Two residents interviewed that mobilise using a mobility device confirms being able to independently mobilise within and outside the facility without problems. The owner manager has documented a number of objectives in relation to maintaining the environment. These are progressively being undertaken and included painting, replacement of the clothes dryer, some of the heaters in the resident rooms and the lounge and replacing some of the lounge furniture. The 2014 quality plan sighted includes a range of facility related projects. Two of two caregivers interviewed advise the owner manager is very responsive to requests for maintenance or required repairs. The staff advise a verbal request is sufficient and all requests are actioned very promptly. Examples provided at Auckland. The staff spoke positively about the facility and equipment changes that have taken place since April 2013.

There is a veranda which 'wraps around' two sides of the rest home with outside furniture available. Five residents have rooms with ranch sliders which enable direct access to the deck. These doors are reported to be rarely used. There is another area under cover down near the garage that residents can use as it is sheltered from the weather.

The new owner manager has purchased a vehicle to take residents to appointments or for use in the activities programme. The vehicle has a current registration and warrant of fitness (sighted). The owner manager is the driver and a copy of the drivers licence sighted. The owner manager also holds a current first aid certificate which is sighted.

The requirements of the ARRC contract are met.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There are three toilets and three showers for residents to use which are located throughout the rest home. These are accessible by all residents. There are eight resident rooms which have toilet ensuites. One resident room on the first floor has a full ensuite. There are signs used to identify when the bathroom or toilet is occupied or vacant. Six of six residents interviewed are happy their privacy is maintained while using these facilities. One resident stated they showered independently and used the privacy locks to ensure their physical privacy.</p> <p>There are hand washing facilities in each resident's room.</p>

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

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

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

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.

Attainment and Risk: FA
Evidence: <p>All residents have single occupancy rooms with the exception of two rooms (in the first floor) which are share twin. One share twin room is in use. There is a privacy curtain placed. The owner manager advises while single rooms are available; the residents sharing enjoy each other's company and do not want their own room.</p> <p>Each bedroom is personalised with residents personal property and has enough space for residents to mobilise independently or with assistance including while using mobility devices. One resident sighted mobilising in their room with a walking stick and another resident uses an electric wheelchair. All six residents interviewed confirm there are no problems with access or space.</p> <p>Two of two caregivers interviewed confirm the residents' rooms are big enough for residents and staff to be in together including when residents require staff or family assistance or supervision.</p>

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>All residents have single occupancy rooms with the exception of two share twin rooms. One of these share twin rooms is occupied at audit (sighted). There is a lounge on the ground floor which is also used for the activities programme. There is a small lounge on the first floor for use by residents who have rooms on this floor.</p> <p>There is a separate dining room which has enough tables and chairs for all residents to be present at meal times. There is a chair at the end of the hallway near the stairwell that can be used by residents who want to rest while mobilising to their room. There is adequate space available to meet residents and family member's needs as confirmed at interview with six of six residents and two of two family member's interviewed.</p>

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

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

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

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.

Attainment and Risk: FA
Evidence: <p>Document review: policies and available (dated April 2013) that detail the process for cleaning the facility, frequency and products to be used. The cleaners job description is include. Policy includes processes for storing chemicals safely.</p> <p>Laundry policy (April 2013) details processes for managing used linen including linen soiled with blood or body fluids, chemical safety and infection prevention and control principals.</p> <p>Stage two: Resident satisfaction in relation to cleaning and laundry services is a component of the satisfaction surveys (sighted). Three responses have been received to the satisfaction survey that is currently in progress. The feedback is positive about cleaning and laundry services provided.</p> <p>Six of six residents interviewed and two of two family members interviewed verify the facility is clean and laundry processes are well managed. One resident states that the resident puts out used laundry 'about once a week for washing and this is returned'. The resident stated if any there was any 'urgent need to have anything washed that staff undertook this quickly when requested'. The resident stated a complete satisfaction with all components of services provided.</p> <p>There is a designated cupboard for the storage of chemicals. This is locked when checked at audit. Two of two caregivers interviewed advise this area is</p>

kept locked to ensure the resident's safety. Two of two care givers interviewed verify they have received training on the safe management of chemicals during orientation and also subsequently. Records sighted identifies six staff attended an in service on safe management of chemicals that was provided by the chemical supplier on 13 February 2014. Attendance records sighted.

The chemical supplier undertakes monthly checks to verify the dilutions of the main chemical in use is within the required parameters and records sighted for the period May 2013 to February 2014.

A cleaning audit was undertaken in April 2013 and all components were compliant with the organisation's policy with the exception of a minor component that related to an individual resident's preferences for the disposal of items.

ARRC contract requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: The health and safety policy (October 2013) includes guidance for staff on managing security. The evening shift must ensure all residents are accounted for by checking rooms and communal areas. Check doors and lock them when it is dark but not later than 8.30pm and turn the outside light on. Ensure all windows without safety/security clasps are securely closed. The afternoon and night shift staff are to sign communications book on completion. Any breeches in security should be referred directly to the senior caregiver for further instruction and be recorded on an incident form.

Stage two: At audit there are designated cupboards that now contains an adequate quantity of bottled water. During audit the owner manager purchased additional quantity of water and dry foodstuffs to ensure there is sufficient supplies to last for all residents to last up to three days. These supplies are kept separate to the main kitchen supplies. There are torches, batteries, disposable plates and crockery, night lights, a radio, personal protective equipment, wet wipes, and portable gas cylinders (for cooking). There are spare blankets and duvets in the linen cupboard.

There is a fire evacuation plan which has been approved by the New Zealand Fire Service on the 26 April 2012 and letter sighted. Fire evacuation drills are held at least six monthly and records sighted. The two caregivers and the RN interviewed confirm a review of emergency and fire safety procedures occurs as a component of the orientation programme and this is confirmed in a review of the orientation programme at audit.

Two of two caregivers confirm they are provided with training on managing emergencies; this includes first aid. A review of the roster verifies there is a staff member with a current first aid certificate (issued by an external company) is on duty at all times. This is verified via review of the roster and copies of staff first aid certificates located in personnel files. In addition an in-house education session on first aid interventions was held in August 2013 and attended by eight staff. An in service on emergency responses and security occurred in October 2013 and is attended by four staff.

Two of two caregivers interviewed who are working the afternoon shift and night shift advise they are responsible for checking all external doors and ensuring they are locked before it gets dark each night. The staff advise they also check all residents' bedroom windows and lounge windows and all doors to ensure they are secure or closed during handover from the afternoon to the night shift. This also enables a physical review to ensure all residents are accounted for.

Organisation policy requires staff to document in the communication book that these checks are done. This is not currently occurring. A memo to staff reminding them of this documentation requirements was given to staff on the second day of audit (and memo sighted). One resident commented that they are not checked on during the night. However, two staff interviewed advise the resident goes to sleep with the window open. The staff advise the window is closed once the resident has gone to sleep. The resident's notes includes documentation from night shift staff on cares provided during the night including the provision of hot beverages. The resident advises feeling 'very safe'. The owner manager, RN and two of two caregivers advise there have been no security concerns reported since the owner purchased the building.

There are portable call bells present in all residents' rooms. These are connected to a receiving device on the wall which identifies which room the call has been initiated in. At audit bells tested at random (three) are fully functioning. These portable call bells can be carried by residents when they leave their bedroom should this be required. Two of two caregivers interviewed confirm all call bells are functioning and should any be noted not to work they will be reported to the owner manager for repair promptly. Six of six residents interviewed confirm staff answer the call bells promptly when they are used. Staff are observed answering the calls bells promptly during audit.

The requirements of the ARRC contract are met.

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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.

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

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

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

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

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

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

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

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

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

Attainment and Risk:FA

Evidence:

All residents' bedrooms have a window of natural proportions which opens. Six of six residents and two of two members interviewed verify the facility is kept warm and well ventilated. There are electric wall mounted heaters or oil heaters in all residents' bedrooms and in the corridors (sighted). Residents stated the owner manager has installed a electric heater in the lounge which looks like a wood fire burning. They really like this.

On the two days of audit all residents' bedroom windows are open plus some of the external doors as it is a warm summer day.

The smoking policy notes residents are only allowed to smoke in a dedicated area (outside under cover on the veranda). The RN advised consideration is given to ensuring the smoke does not drift into other resident areas. Staff advise they are not allowed to smoke on the premises.

ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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.

Attainment and Risk: FA
Evidence: Document review: the restraint minimisation and safe practice policy notes it is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention. Equipment, devices or furniture, voluntary used by a resident following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and / or safety are enablers The least restrictive option is to be

used.

Examples include:

- raised bedsides to assist resident's mobility in bed, to aid the positioning of pillows for comfort or to prevent falls from the bed.
- a tray in front of resident's chair to allow independence with meals
- a lap belt while in a wheelchair.

The policy notes there will be an open and frank discussion with resident and/or relatives regarding the pros and cons of the intervention ensuring that risks are understood. This need to be documented as such on their care plan and the resident is informed that they have to indicate to staff when they like this enabler put in place and when it is to be removed. If unable to do so, then there will be a discussion regarding appropriate monitoring time frames which will reflect risks. An assessment is completed to establish the risk of using the enabler. Monitoring needs to be completed at least every two hours or more frequently when risk is assessed as higher.

A consent form stating the above is completed. This form can be signed on the resident's behalf, by an authorised person. Use of enablers is to be evaluated at least six monthly.

Stage two: Currently the service has no restraint or enablers in use. This is confirmed in the annual restraint review sighted. The RN restraint coordinator demonstrates an in depth knowledge of safe restraint minimisation practices. Her role is clearly described in her job description. Three of three caregiver interviews identify their understanding and knowledge of actions to be taken should restraint be required.

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

Attainment and Risk:FA

Evidence:

Document Review: There are a number of infection prevention and control policies which provide guidance for staff on how to prevent or minimise the spread of infection. The types of pathogens which can be spread are identified along with the transmission based precautions required and duration. A separate protocol details the steps that should be taken in the event of pandemic influenza. This also details the signage that should be placed at the facility. The policy notes that residents are offered the opportunity of having annual influenza vaccinations (with prior consent).

The infection control policy (January 2013) states 'the purpose of infection control is to limit the acquisition and spread of pathogenic micro-organism by using scientifically based knowledge and thorough planning, surveillance, education and research as part of the overall policy of achieving good quality health care. This infection control programme is developed in consultation with relevant key stakeholders, (microbiologist, registered nurses and other health professionals). Management, including the RN (who is responsible for infection control activities) approve the programme. The programme is reviewed at least annually.

The documented quality and risk management programme aims to minimize the risk of preventable healthcare associated infections in order to deliver healthcare safely and cost effectively. The plan includes:

- identification and management of risks
- collect infections surveillance data, analyse for trends and where possible implement corrective action plans to prevent recurrences.
- policies and procedures for the prevention and control of infection
- modifying or changing procedures, protocols and work practices based on updated good and safe practice guidelines, changed legislation, monitoring of health outcomes for residents, staff and visitors
- compliance with current standards, contract and legislation
- provide information, education and training to staff, residents and visitors

Stage two: A review of the infection control programme is sighted and is dated 15 January 2014. All objectives from 2013 plan are reported to have been fully met. The RN advises she meets with the owner manager on a regular basis most days and ensures the owner manager is kept fully aware of changes in residents' health and any infection prevention and control concerns. This is verified by the owner manager who confirms timely ongoing communication is occurring. Two of two caregivers interviewed confirm they are required to report any infection prevention control concerns to the RN in a timely manner. The RN advises there have been no outbreaks of infection in 2013. All mounted hand sanitisers are sighted readily available throughout the facility to assist with hand hygiene practices. Portable bottles of hand gel are reported to be available if needed for use in individual resident room.

Two resident newsletters have been issued to residents and family members (Autumn 2013 and Summer 2014). Both newsletters promote hand hygiene and recommend visitors do not come if they are sick. Newsletters sighted at audit.

The RN advises all residents present in the rest home in March 2013 consented and were administered influenza vaccination by the GP.

The ARRC contract requirements are met.

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk:FA

Evidence:

Document review. The infection control programme (January 2013) identifies that the local laboratory will be invited to educate staff on infection control principles at least once a year.

In case of an outbreak advice will be sought from GP and Laboratory services. The RN is responsible to for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.

Stage two: The RN confirms she is responsible for infection prevention and control activities. The RN has attended relevant education on infection prevention and control including a study day at ADHB in the last year. (Refer to 1.2.1.) The RN advises she liaises with the GP if there are any concerns about a resident with a known or suspected infection.

The ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Document review: There are a range of infection prevention and control policies which provide guidance for staff on how to prevent the development and spread of infection. The policies are clear. All required policies to meet the standards are present. The policies have been reviewed in the last two years.

Stage two: Two of two caregivers interviewed confirm they have access to policies on infection prevention and control. Should they have any concerns they would contact the RN who is on call when not on site. The GP confirmed during telephone interview he is contacted by staff in a timely manner when the needs of the resident have changed.

The ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk:FA

Evidence:

Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. An in-service on hand hygiene and outbreak prevention/management occurred in 2013 which is attended by five staff. Safe food handling principals was included in a nutrition and hydration in-service in May 2013 which is attended by four staff. Attendance records are sighted.

Residents and family are provided with advice on infection prevention and control activities via newsletters. The Autumn 2013 and Summer 2014 newsletters sighted included requests for waterless hand gel to be used when visiting and to avoid coming on site to visit if unwell. The RN advises information on influenza and the influenza vaccine is provided to residents each year in February/March when consent is obtained for the annual influenza vaccination.

Refer to 1.2.1 for information on the training undertaken by the RN on infection prevention and control topics.

The ARRC contract requirements are met.

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

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

Attainment and Risk:FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

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

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

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

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

Attainment and Risk: FA
Evidence: Document review: The infection control programme includes surveillance for the following types of infection: - urinary tract infections -respiratory infections -skin infections -wound infections -scabies -conjunctivitis -gastroenteritis The programme includes documented definitions of infections (sighted). The surveillance method is also defined and suspected infections are to be reported on a template form. There is to be monthly analysis of infections. Stage two. Surveillance for residents with infections is occurring. Two of two caregivers interviewed advise they are responsible for advising the RN if they

are concerned a resident has an infection. The staff are able to identify the common signs and symptoms of infections. The caregivers advise they can also contact the GP directly if they are concerned. This is verified by the RN during interview who confirms staff identify quickly the early signs of infection to enable prompt management.

A review of the infection surveillance data for 2013 and January 2014 identifies there are normally low rates of infections reported each month. An annual report sighted analysing the infection surveillance data for 2013 and commenting on the likely contributing factors and actions undertaken to reduce infections. This includes encouragement of residents and staff to use the waterless hand gel and offering additional fluids. There is a water cooler that residents can independently obtain a drink from. In addition staff offer residents a beverage between morning tea and lunch and between afternoon tea and dinner if they would like one. The RN advises a copy of the annual report was provided to the owner manager and a copy shown to the GP during a visit. The most common category of infection in 2013 is chest infection.

A review of the surveillance data for November 2013, December 2013 and January 2014 and a review of the applicable resident notes verifies short term care plans are developed as required. The residents' files reviewed by the second auditor verifies infections are being reported.

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.

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

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

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

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