

Methven Aged Person's Welfare Association Incorporated

Current Status: 5 March 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

Methven House is a twelve bed rest home, which on the day of audit was full with the respite bed occupied. The facility is a registered charity in a rural mid-Canterbury township that is governed by a committee with community representation. A nurse manager oversees the management and reports to the committee.

There is evidence of significant changes having been made to ensure the service meets the required standards. Overall, staff, residents and family members are very satisfied.

Six areas for improvement, all of low risk, have been identified in this certification audit. These relate to the checking of medical equipment, the recording of employment processes, archiving residents' records, the development of activity plans, monitoring the menu and infection surveillance documentation.

Audit Summary as at 5 March 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	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 5 March 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 5 March 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 5 March 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.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 5 March 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 5 March 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 5 March 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.		Some standards applicable to this service partially attained and of low risk.
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Audit Results as at 5 March 2014

Consumer Rights

A complaints procedure is in place and staff and residents are familiar with this. There are no complaints in the complaints log as none have been received since this system was implemented.

The admission process to the facility is planned and timely. Consent forms are provided prior to admission to ensure residents and family have time to consult with others and are fully informed. Time and space for discussions to occur is provided.

There is evidence of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence. Residents and family interviewed state that staff are very respectful of their needs, that communication is appropriate, they are given time for discussions to take place, and have a clear understanding of their rights and the facility's processes if these are not met. The facility takes extra care to ensure that privacy in shared rooms is managed.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) including the facility's complaints process, and the Nationwide Advocacy Service is on display in the main hallway, is available on admission in the admission package, and on request.

An area for improvement relates to the need for medical equipment to be checked and calibrated, according to best practice.

Organisational Management

A mission statement and philosophy focus on the residents and their needs. Overall, planning processes are comprehensive with a current business, quality, risk and management plan that includes nursing and organisational goals and objectives. The manager provides the committee with a monthly report that includes quality and organisational management data and information. Staff receive this information at two monthly meetings.

Quality systems are well organised and include monitoring and corrective action processes, surveys, incident report data and analyses, policy and procedure updates and health and safety monitoring.

Human resource processes are overseen by the manager. Annual practising certificates are recorded, a comprehensive orientation programme is in place and being used and there are ongoing opportunities for staff training for staff at all levels in all roles. An area for improvement is the need to consistently record employment processes such as initial interviews and referee checks and to complete three monthly and annual performance appraisals, some of which are overdue.

A staffing level and skill mix policy, on which the roster is based, is available. Staffing levels meet requirements and are adjusted according to acuity levels of residents' needs.

The archiving of residents' records into integrated files is also an area for improvement.

Continuum of Service Delivery

There is a detailed admission information package that provides the process for admission to the Methven Home, including the need for all residents to be assessed prior to admission, and that the facility is rest home only level of care.

The facility has a fully implemented interRAI assessment programme. The nurse manager completes the assessment, from which an individualised, detailed care plan is generated. Regular reviews occur to reflect the resident's assessed needs. Hardcopy short term care plans are developed when issues arise within the review timeframe. Staff are observed during the audit providing service in a quiet, respectful and dignified manner, reflective of the care plan content. This is also supported in family and resident interviews.

A general practitioner (GP) is interviewed during the audit and confirms the facility provides a high level of care and assessments and service delivery are appropriate and in line with his treatment recommendations.

An activities programme is managed and implemented by an activities person, providing a variety of group and individual activities to meet the interests of the residents. However individual activity plans do not always reflect these needs and this is an area of required improvement.

A 'blister pack' medication system is implemented and care staff assessed as competent to do so, follow a GP prescription record to administer the medications. This process is observed on the day of the audit. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as changes occur.

A dietary profile is completed for each resident on admission and any special dietary needs are met. The kitchen service is managed from within the facility, with night staff preparing the meals, however not all those on the night shift have the appropriate food and hygiene training and this needs addressing. A nutritional review of the menu occurred in July 2013 and recommendations have been implemented, however this is not always taken into account when the menu is altered, and this requires improvement. Personal likes and dislikes are catered for and birthdays and other events are celebrated. Appropriate monitoring of food transportation, storage and preparation is occurring. Not all frozen food is labelled and dated to ensure stock rotation occurs and this is an area of required improvement.

Safe and Appropriate Environment

There are systems in place for the safe disposal of rubbish, the identification of hazards and the safe storage of chemicals. Personal protective equipment is being used.

The facility has a current building warrant of fitness, electrical checks are being done and checks of fire systems and equipment are being maintained.

Overall the building has easy access, the residents are safe mobilising inside and outside, the toilet, shower and hand washing facilities are adequate and bedrooms are of a good size. There are three shared rooms. The residents have access to a dining room and to a lounge, which has a sunroom that can be closed off for additional privacy.

Staff undertake emergency training annually, the fire evacuation plan has been approved, the call bell system is operational and security systems are in place. Emergency equipment is available and the service is prepared for the potential adverse effects of snowfalls. Cleaning and laundry processes are monitored.

All rooms have windows that can be opened for ventilation and there is electric heating throughout.

Restraint Minimisation and Safe Practice

Methven House is a restraint free environment and there are not currently any enablers in use. Policies and procedures that describe enablers and the different types of restraint are available should the need arise. These include assessment, review and monitoring processes. Education on restraint use and on managing challenging behaviours is on the staff training schedule and staff report they are given additional guidance on the management of any resident with challenging behaviours when the need occurs.

Infection Prevention and Control

There is a documented Infection Prevention and Control (IC) Programme which contains all requirements in the Infection Control Standards. Policies and procedures guide staff in all areas of infection control practices. The nurse manager NM is supporting the recently appointed IC registered nurse (RN), and these two form the infection control (IC) team. Records sighted and interviews demonstrate they have a clear understanding of what is required to implement the IC programme. They are able to gain advice from a variety of external sources, including the IC nurse specialist, who also provides annual training. The GP is also consulted regarding individual residents' infections.

Surveillance of IC data is occurring, however analyses to minimise reduction in infection has not been documented and this requires improvement.

All staff receive IC education on induction and orientation, and at least annually. There is evidence that residents and family are educated in IC practices for specific practices and when visiting the facility.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Methven Aged Person's Welfare Association Incorporated
Certificate name:	Methven Aged Person's Welfare Association Incorporated
Designated Auditing Agency:	The DAA Group Limited
Types of audit:	Certification Audit
Premises audited:	Methven House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 March 2014 End date: 5 March 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:	12

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	8
Other Auditors	XXXXX	Total hours on site	8	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	XXXXX			Hours	3

Sample Totals

Total audit hours on site	16	Total audit hours off site	19	Total audit hours	35
Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	17	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 31 March 2014

Executive Summary of Audit

General Overview

Methven House is a twelve bed rest home, which on the day of audit was full with the respite bed occupied. The facility is a registered charity in a rural mid-Canterbury township that is governed by a committee with community representation. A nurse manager oversees the management and reports to the committee.

There is evidence of significant changes having been made to ensure the service meets the required standards. Overall, staff, residents and family members are very satisfied.

Six areas for improvement, all of low risk, have been identified in this certification audit. These relate to the checking of medical equipment, the recording of employment processes, archiving residents' records, the development of activity plans, monitoring the menu and infection surveillance documentation.

Outcome 1.1: Consumer Rights

A complaints procedure is in place and staff and residents are familiar with this. There are no complaints in the complaints log as none have been received since this system was implemented.

The admission process to the facility is planned and timely. Consent forms are provided prior to admission to ensure residents and family have time to consult with others and are fully informed. Time and space for discussions to occur is provided.

There is evidence of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence. Residents and family interviewed state that staff are very respectful of their needs, that communication is appropriate, they are given time for discussions to take place, and have a clear understanding of their rights and the facility's processes if these are not met. The facility takes extra care to ensure that privacy in shared rooms is managed.

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An area for improvement relates to the need for medical equipment to be checked and calibrated, according to best practice.

Outcome 1.2: Organisational Management

A mission statement and philosophy focus on the residents and their needs. Overall, planning processes are comprehensive with a current business, quality,

risk and management plan that includes nursing and organisational goals and objectives. The manager provides the committee with a monthly report that includes quality and organisational management data and information. Staff receive this information at two monthly meetings.

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A staffing level and skill mix policy, on which the roster is based, is available. Staffing levels meet requirements and are adjusted according to acuity levels of residents' needs.

The archiving of residents' records into integrated files is also an area for improvement.

Outcome 1.3: Continuum of Service Delivery

There is a detailed admission information package that provides the process for admission to the Methven Home, including the need for all residents to be assessed prior to admission, and that the facility is rest home only level of care.

The facility has a fully implemented interRAI assessment programme. The nurse manager completes the assessment, from which an individualised, detailed care plan is generated. Regular reviews occur to reflect the resident's assessed needs. Hardcopy short term care plans are developed when issues arise within the review timeframe. Staff are observed during the audit providing service in a quiet, respectful and dignified manner, reflective of the care plan content. This is also supported in family and resident interviews.

A general practitioner (GP) is interviewed during the audit and confirms the facility provides a high level of care and assessments and service delivery are appropriate and in line with his treatment recommendations.

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A 'blister pack' medication system is implemented and care staff assessed as competent to do so, follow a GP prescription record to administer the medications. This process is observed on the day of the audit. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as changes occur.

A dietary profile is completed for each resident on admission and any special dietary needs are met. The kitchen service is managed from within the facility, with night staff preparing the meals, however not all those on the night shift have the appropriate food and hygiene training and this needs addressing. A nutritional review of the menu occurred in July 2013 and recommendations have been implemented, however this is not always taken into account when the

menu is altered, and this requires improvement. Personal likes and dislikes are catered for and birthdays and other events are celebrated. Appropriate monitoring of food transportation, storage and preparation is occurring. Not all frozen food is labelled and dated to ensure stock rotation occurs and this is an area of required improvement.

Outcome 1.4: Safe and Appropriate Environment

There are systems in place for the safe disposal of rubbish, the identification of hazards and the safe storage of chemicals. Personal protective equipment is being used.

The facility has a current building warrant of fitness, electrical checks are being done and checks of fire systems and equipment are being maintained.

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All rooms have windows that can be opened for ventilation and there is electric heating throughout.

Outcome 2: Restraint Minimisation and Safe Practice

Methven House is a restraint free environment and there are not currently any enablers in use. Policies and procedures that describe enablers and the different types of restraint are available should the need arise. These include assessment, review and monitoring processes. Education on restraint use and on managing challenging behaviours is on the staff training schedule and staff report they are given additional guidance on the management of any resident with challenging behaviours when the need occurs.

Outcome 3: Infection Prevention and Control

There is a documented Infection Prevention and Control (IC) Programme which contains all requirements in the Infection Control Standards. Policies and procedures guide staff in all areas of infection control practices. The nurse manager NM is supporting the recently appointed IC registered nurse (RN), and these two form the infection control (IC) team. Records sighted and interviews demonstrate they have a clear understanding of what is required to implement the IC programme. They are able to gain advice from a variety of external sources, including the IC nurse specialist, who also provides annual training. The GP is also consulted regarding individual residents' infections.

Surveillance of IC data is occurring, however analyses to minimise reduction in infection has not been documented and this requires improvement.

All staff receive IC education on induction and orientation, and at least annually. There is evidence that residents and family are educated in IC practices for

specific practices and when visiting the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	39	0	6	0	0	0
Criteria	0	87	0	6	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	PA Low			
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	PA Low	The current system for the checking and calibration of measuring and monitoring equipment is not being implemented according to accepted good practice. For example, scales are checked by weighing a bag of rice. The unsuitability of this system is evident in the significant weight difference for a resident	That a system is implemented to ensure equipment used for measuring and monitoring purposes is checked and calibrated by suitably qualified people and within scheduled timeframes.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				when a new set of scales was purchased.		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Recruitment and induction systems in place to ensure the appointment of appropriate service providers are not all being implemented, as per organisational policies and procedures. Not all staff files of recently employed staff have evidence of initial interviews, or of referee checks being done. Also some staff performance appraisals are overdue, including those for new employees who have been at the facility for more than three months.	That systems to ensure the appointment of appropriate service providers are fully implemented.	180
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.10	All records pertaining to individual consumer service delivery are integrated.	PA Low	Admission agreements for past residents are retained in the administration office and	All records pertaining to past records are archived in one integrated file for each resident.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				not integrated into the past residents' archived files.		
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Individual activity plans reviewed do not reflect the resident's current interests and social activity, for example one resident who visits her family weekly, prunes the roses, attends to her potted plants and is actively attends political meetings monthly, does not have this included on her activity plan. Goals are not specific to the activity and are generalised, for example, goals include "maintain participation" or "maintain interest" and of those reviewed only one has been evaluated, and this was in July 2013.	Activity plans include activities that are meaningful to the resident, include goals and are evaluated at least six monthly.	180
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food	PA Low	The menu is altered if the	All aspects of food	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		required food stock is unavailable, however implementation of the dietitian's recommendations regarding the inclusion of fruit and milk based portions does not always occur. Implementation of other recommendations regarding documenting afternoon tea and supper baking is also not occurring. The registered nurse works occasional night shift, however does not have the food and safety training requirements. There are observed opened products in the freezer that are not dated or labelled.	procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines	
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low			
HDS(IPC)S.2008	Criterion 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.	PA Low	Surveillance data is occurring, however analyses, conclusions and specific recommendations to minimise reduction in infection have not been documented.	Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and managed in a timely manner.	180

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.

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

Attainment and Risk: FA
Evidence: Consumer rights' training occurs at least annually (records sighted). Care staff are observed communicating respectfully and appropriately with residents and allowing residents to make choices (for example where they wish to sit, group activity, and dining room attendance), demonstrating their knowledge of residents rights. Residents (four of four) and family member (one of one) confirm that services are provided with dignity and respect at all times and individual needs and rights are upheld. The ARRC requirements D1.1c; D3.1 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

Residents (four of four) and family (one of one) interviewed, including two residents who are recent admissions to the facility, verify that they are provided with information regarding The Code of Health and Disability Services Consumers' Rights (the Code), and the Advocacy service, on admission. According to those interviewed, explanations regarding their rights occur initially and on-going at any time that they may have a query, and they are aware that an advocate may be appointed if needed. None of those interviewed have required the service.

A large consumer rights poster, consumer rights' brochures, and information on the Nationwide Advocacy Service are available (sighted) at the entrance of the facility, and include information on providing feedback, complaints and compliments.

The ARRC requirements D6.1; D6.2; D16.1b.iii 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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.

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

Attainment and Risk: FA
Evidence: <p>A policy (January 2014) covering privacy, dignity and preserving autonomy is sighted. This policy includes collection, storage and security of information. There is also a policy on residents' safety, neglect and abuse prevention and security that describes the different types of abuse and provides guidelines for managing any incidents of suspected abuse or neglect.</p> <p>Residents and the family member interviewed have not been subject to, or witnessed, any abuse or neglect. Those interviewed maintain the carers and all staff show respect at all times, by knocking when entering rooms (observed), facilitate private conversations (including in shared bedrooms), understand residents' particular values and beliefs and encourage independence (observed care staff enabling, and verbally encouraging walking aid independence).</p> <p>The ARRC D3.1b; D3.1d; D3.1f; D3.1i; D4.1a; are met.</p>

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

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

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

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 1.1.3.7 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: A cultural safety policy (November 2013) provides guidelines for the provision of culturally safe services for Maori residents, includes a section on cultural awareness that describes a Maori perspective of health, the importance of whanau, an assessment plan for Maori residents and a section on cultural responsiveness for Maori residents. The Treaty of Waitangi is noted as being accepted and ways of providing culturally safe care in line with Treaty of Waitangi expectations. There are no Maori residents in the facility at the time of the audit, and according to the nurse manager there have been no residents who identify as Maori since the previous audit.

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>

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

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

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

Attainment and Risk: FA

Evidence:

Alongside the strong policy and procedures to address the needs of Maori residents in the cultural safety policy, there is a section on cultural responsiveness for people of other cultures. This notes the involvement of family whenever possible; the need to access interpreters and the need for sensitivity and respect of cultural differences. Residents and the family member interviewed verify the facility regularly ensures their individual values and beliefs are met. An example is one resident (interviewed) who walks to her own church close to the facility. Care staff ensure the resident is groomed and appropriately dressed early enough for this to occur on a weekly basis.

The ARRC requirements D3.1g; D4.1c 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.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The residents' rights policy (reviewed) includes guidelines to ensure residents are free from any discrimination, coercion, harassment, sexual, financial or other exploitation. Care staff interviewed demonstrate awareness of the residents' rights in relation to these.

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: PA Low

Evidence:

Induction and orientation for staff are aligned to best practice processes. Each staff member has a written scope of practice included in their position description (sighted), including if they have multiple roles (for example the RN is also the infection control co-ordinator).

In-service education and on-going professional development is provided and supported by the organisation (records sighted). Policies and procedures are all current and reflect good practice guidelines.

The facility has a fully implemented interRAI `assessment and formatted care plan for all residents. The Nurse Manager (interviewed) is trained in the programme with

plans for the registered nurses (RN) to complete training this year.
 Staff working in different areas are observed to utilise personal protective equipment suitable to the environment and reflective of the policy and procedure for the area, for example, care staff who also work in the kitchen and the laundry.
 Systems in place for monitoring and measuring equipment are not currently in line with accepted best practise. This is an area for improvement.

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: PA Low
Evidence: The manager has implemented systems in an attempt to check and calibrate equipment used for measuring and monitoring such as weighing scales, sphygmomanometers and tympanic thermometers. The processes used for checking equipment to date have not been according to best practice as scales are tested using a bag of rice for example. There is also a lack of awareness of where equipment may be checked and/or calibrated.
Finding: The current system for the checking and calibration of measuring and monitoring equipment is not being implemented according to accepted good practice. For example, scales are checked by weighing a bag of rice. The unsuitability of this system is evident in the significant weight difference for a resident when a new set of scales was purchased.
Corrective Action: That a system is implemented to ensure equipment used for measuring and monitoring purposes is checked and calibrated by suitably qualified people and within scheduled timeframes.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA
Evidence: An Open Disclosure policy and procedure includes a definition, describes key principles and explains expectations of procedures for the service. Staff training, limits on disclosure and references enhance the policy document. Residents and the family member interviewed verify communication is appropriate and in a manner the resident can understand. Care staff are observed taking time to ensure when communicating with a resident who does not always verbalise correctly her needs, that what she has said is actually what she wishes.

The facility nurse manager (NM) and registered nurse (RN) are interviewed and confirm they have not needed to access interpreter services at all in the facility, although policies and procedures are in place should these be required.

The 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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

Attainment and Risk: FA

Evidence:

Informed consent policy and procedures are outlined in policy documentation. This includes references to the Code of Rights, the Code in relation to competence and steps to take when a consumer is not competent. Information on healthcare advance directives, living wills, the release of health information and a resuscitation information pack is sighted. There is also a policy on resuscitation protocol and a consent form. Associated forms sighted include a Health Practitioners Certificate of Mental Incapacity form, Advance Directive form, two for specific consents, an informed consent form and a medical information release consent form. Admission agreements are signed by the resident and/or their family member on admission to the facility, and information included is aligned to the ARRC agreement requirements (four of four resident agreements reviewed). Four resident files reviewed include appropriate consent forms (resuscitation, collection and storage of information, outings, flu vaccinations and consent to provide care).

The ARRC requirements D3.1d; D11.3; D12.2 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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.

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

Attainment and Risk: FA

Evidence:

There are policies and procedures (sighted) that include the right of residents to have an advocate or support person of their choice. Residents (four of four) and family (one of one) interviewed, confirm that family and support persons are included in discussions relating to care provision. The multidisciplinary team meeting (forms sighted) includes input from the resident's family member (documents sighted). Care staff (interviewed) are aware of the residents' rights to have a support person of their choice at any time.

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

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

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

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

Attainment and Risk: FA

Evidence:

All residents and family interviewed verify that family and visitors of their choice are able to visit residents at any time. External community links are encouraged and enable to continue. One resident (interviewed) visits her family for afternoon tea each week, while another (interviewed) walks to town to get her hair done and regularly goes out to lunch with friends. Progress notes and care plan content includes regular outings and appointments (records sighted).

The ARRC requirements D3.1h; D3.1e 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

Attainment and Risk: FA

Evidence:

A complaints policy and procedure that meets the timeframes as noted within the Health and Disability Consumer Code of Rights is sighted. This policy notes the lines of authority/responsibility, staff responsibility and a complaints management flowchart. Information for staff on dealing with complaints is attached to the policy. A complaints and compliments form, a form for complaints follow-up and a blank copy of the complaints register are also sighted during stage one audit. Copies of complaints forms are viewed in the hallway during a tour of the facility, a box for people to place compliments and complaints in sits beside them and staff demonstrate during interview that they are familiar with the complaints process. There have not been any complaints involving residents since the last certification audit, which the manager informs is the reason for the blank complaints register. A complaint involving another staff person was investigated and actioned by the manager early in 2013 with records retained in the staff person's file.

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>The service provider's mission statement notes a home for the aged, embracing the needs of all, irrespective of culture, race or creed will be provided for. The philosophy statements centre around assisting residents towards independence, encouraging the involvement of whanau/family; encouraging a high level of wellness, facilitating the mixing of residents and joining in activities; encouraging residents to be involved externally, in particular, culturally and spiritually; the acknowledgement of cultural differences; and notes the need to meet best practice guidelines.</p> <p>There is a business, quality, risk and management plan last reviewed February 2014. Nursing and organisational goals and objectives are in place with the latter coming under the quality and risk plan. The manager reports to a committee of trustees, which provides a governance structure to the service and the chairperson of the committee explains the community consultation processes and level of community involvement during interview.</p> <p>The nurse manager, otherwise known as the manager, is suitably qualified and experienced. She is a registered nurse and has been in this role for six and a half years. In addition to a Bachelor of Nursing, the manager has completed tertiary qualifications in palliative care. The manager's curriculum vitae confirms she is maintaining her professional development and informs of her previous experience in an aged care facility and her extensive experience as a district nurse. During interviews, the residents, the governance committee and staff are positive about the manager's commitment to the role.</p>

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.

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

Attainment and Risk: FA

Evidence:

On the last Monday of each month, the manager provides monthly reports to the committee prior to their meeting. These are referenced in the committee meeting minutes sighted. The minutes include reports and discussion on topics of residents, staff, education, activities, hazards/risks, statistics and maintenance, for example. An annual meeting with the community is held in the middle of each year.

During any temporary absence of the manager, the registered nurse steps into the manager's role. The registered nurse has extensive nursing experience and expresses a passion for ongoing tertiary education and training on a wide range of health and nursing related topics. This is confirmed in the records sighted in her personal staff file.

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.

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

Attainment and Risk: FA

Evidence:

The business, quality, risk and management plan has a series of separate objectives and management controls with note of who is responsible and the measurement process under the topics of consumer focus; provision of effective programmes; certification and contractual requirements; risk management and continuous improvement. Implementation of this plan and review of its components are evident in monthly committee meetings minutes and in two monthly staff meetings minutes sighted.

A document control system has been implemented and there is a process in place to ensure the manager reviews and makes any necessary corrections to documents, which are then approved by the committee. Only the administrator can physically change any documents. A quality consultant oversees the management of the controlled documents and provides the service with any new information that aligns with good practice and any legislative or regulatory changes. Staff sign confirmation that they have read any changed or new documents. Policies and procedures sighted during the document review include those as listed in the ARRC agreement D5.4 and D19.2.

Key components of the quality management system are being addressed as per the management plan and evidence of their review is recorded in committee and staff meeting minutes. A list of quality improvements for 2013 includes a diverse range of identified factors that have been addressed. These include repairs to the environment, corrective actions undertaken for shortcomings, solutions to problems and the reorganisation of systems, such as for emergency supplies. The residents' survey was undertaken in July 2013, the feedback was analysed at the end of 2013 and the results shared with staff early 2014.

A corrective action process is explained as are monitoring, assessment, action, evaluation and feedback processes. This confirms regular staff meetings provide a forum for discussing quality issues and that minutes of all meetings are maintained and follow the same topics. The issues discussed are recorded and the follow-up documented.

More than 25 quality indicators have been established and an internal audit system within the quality and risk management system contributes to the monitoring of them. The internal audit system includes a list of issues to be checked that include hot water and refrigerator temperature monitoring, fire evacuation trials, environmental assessments and food service and resident care audits.

There is a comprehensive health and safety policy, which has its own index and includes commitment statements, an outline of communication channels, investigation processes, hazard identification and related documents and security procedures. Ongoing hazards and those that have been eliminated are recorded within a hazard register. New hazards are identified on a hazard identification form.

Risks are identified within the risk management section of the business, quality risk and management plan and risk management is one of the focus topics with its own set of objectives and management controls. This separate risk management plan was reviewed between stage one and stage two audit and notes ways to mitigate the identified risks, provides measures of the level of risk and actions align with their management. Most aspects of the risk management system have been reported within the wider quality management system throughout the past year.

Incidents and accidents are being reported on the designated form and these are being analysed. Common problems and trends are reported to staff and ideas to reduce their incidence are discussed and recorded. For example February 2014 meeting minutes include a month by month annual report on skin tears for 2013 with contributing

factors noted.

Quality meeting minutes include staff and education reports, residents' progress, and activities, reviews of policy documents, maintenance concerns and general quality related statistics.

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

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

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

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

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

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

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 1.2.3.7 (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.

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

Attainment and Risk: FA
Evidence: <p>A policy on accident and incident reporting notes the need to report all such events and references the open disclosure policy and the incident/accident report form/non-conformance. The policy notes actions for different types of incidents and that all reports will be presented to the committee and staff meetings. Completed incident forms include 11 options of categories, which are used to assist the analysis of such events. It includes a section for updated progress notes that is completed when relevant and a section that identifies who has been contacted</p> <p>Committee and staff meeting minutes report on incidents and accidents monthly and two monthly respectively. Annual reports are provided on the key categories of medication errors, falls and skin tears/wounds. Four incidents reported for 2013 fall outside these three key categories.</p> <p>The manager is aware of her responsibilities around essential notifications, although has not had to report any such events. . Examples reported during interview include quarterly reports to the District Health Board, reports of any outbreaks, serious incidents and any missing person. Other examples are the need to report any suspicious death to the police and any intrusion, or presence of an aggressive person.</p>

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): <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.

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

Attainment and Risk: PA Low

Evidence:

A good employer policy (September 2013) notes the organisation offers equal employment opportunities. Sexual harassment is described as are actions to be taken should this occur and there is a discrimination/harassment procedure flowchart. The complaints and investigation processes are also described. Under 'staffing', the policy notes practising certificates are viewed and held on file for all registered staff, that staff will receive ongoing education and performance appraisals will be carried out annually and as needed.

Records of annual practising certificates are sighted for the nurse manager, the registered nurse, an enrolled nurse, two GPs and the local pharmacists.

An orientation programme that covers key information and safety topics is documented within human resource policies and procedures and orientation records are on file for all except two of the seven staff files viewed. One person is still completing this and another was employed prior to orientation programmes being an essential element of employment. The recording of employment processes to ensure appropriate service providers are employed is an area for improvement. For example, initial interviews, referee checks; three monthly and annual performance appraisals are not evident in all staff files reviewed.

A staff training schedule is sighted. A different topic is allocated for each month and cover core topics of infection control, privacy, confidentiality and rights, manual handling, emergency management and restraint minimisation for example. Staff report during interview that they are also provided with training on topics that become issues of concern with an example being managing residents with confusion. Records of staff attendance and attainment of certificates are filed in their personal staff file(s). All staff have a current first aid certificate except for a new person who is booked in for the next opportunity and all staff who administer medicines have a current medication competency. Caregivers are at different levels of attainment of certificates through Aged Care Education. They also attend external training when this is considered advantageous, such as InterRAI for the registered nurse.

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

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

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

Attainment and Risk: PA Low

Evidence:

There is no evidence to suggest that any staff person who is currently employed is not appropriate. However, there is a lack of evidence in staff files that all employment processes are being implemented according to organisational policies and procedures and according to best practice. Application forms are not fully completed, or on file, records of initial interviews are not being retained and nor is there consistent evidence of referee checks being done. Evidence of the initial three month appraisal and/or of annual performance appraisals is not available in three of the seven staff files reviewed and not in a fourth when the sample size is extended.

Finding:

Recruitment and induction systems in place to ensure the appointment of appropriate service providers are not all being implemented, as per organisational policies and procedures. Not all staff files of recently employed staff have evidence of initial interviews, or of referee checks being done. Also some staff performance appraisals are overdue, including those for new employees who have been at the facility for more than three months.

Corrective Action:

That systems to ensure the appointment of appropriate service providers are fully implemented.

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

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

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

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 1.2.7.5 (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.

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

Attainment and Risk: FA
Evidence: <p>The good employer policy notes the nurse manager or a registered nurse is always on call as specified in the roster and that a staff member will be on duty at all times. A section on staffing notes the responsibility for appropriate safe and workable numbers lies with the nurse manager and a section on staffing levels and skill mix notes the nurse manager may extend hours and staff numbers to respond to issues such as resident acuity or special events. It notes the appropriate skill mix will be reflected in the roster, that junior staff will always be supervised by a senior staff member until deemed competent, that senior staff will have the necessary competencies and a complement of auxiliary staff are rostered on during day time hours.</p> <p>All staff undertake first aid training and this is kept updated as required. Records sighted show a new staff person is the only person who does not have a current first aid certificate and her name is down for the next course. This person is not currently rostered alone. The registered nurse is contracted for 24 hours a week, is rostered on call for one weekend a month and replaces the manager full time when the nurse manager goes on leave. A roster framework is sighted and four weeks of rosters are consistent with this and with the minimum requirements of the ARC agreement. . The manager works 8.00am to 4.30pm Monday to Friday. Caregiver shifts are 6.45am to 3.15pm; 7.30pm-11.30pm; 2.45pm-11.15pm; 4.30pm-8.30 and 11pm to 7am.The 4.30 to 8.30 does an 8am to 10pm shift at weekends. An activities person is rostered each day Tuesday to Friday.</p>

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.

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

Attainment and Risk: PA Low
Evidence: <p>New admission records have the information recorded on the day of admission and always within 24 hours of admission (four of four files reviewed including T 1). The residents' records contain information to safely identify the residents and are legible signed and dated. There are integrated notes on the residents' progress completed each shift by care staff and if required by the RN or NM (interviewed). Residents' records sighted are kept secure in the office when not in use. A signing register is maintained (sighted) that includes all staff, the four GPs and the pharmacist.</p> <p>Current residents' old notes and archived records are secured in a room specific for records. These are organised and dated for easy retrieval (sighted).</p> <p>Admission agreements for past residents (observed) are retained in the administration office and not integrated into the past residents archived file and this requires improvement.</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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: PA Low
Evidence: There are integrated notes on the resident's progress completed each shift by care staff and if required by the RN or NM (interviewed). Residents' records sighted are integrated, and kept secure in the office, when not in use. Admission agreements for past residents (observed) are retained in the administration office and not integrated into the past residents archived file.
Finding: Admission agreements for past residents are retained in the administration office and not integrated into the past residents' archived files.
Corrective Action: All records pertaining to past records are archived in one integrated file for each resident.
Timeframe (days): 180 <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.

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

Attainment and Risk: FA

Evidence:

Entry to service documents include an admission package and brochure that details all requirements for both parties on admission to the facility. Admission agreements are completed for all residents including those private paying (four of four records sighted). A needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions (records sighted) to ensure admission is appropriate.

Residents and family interviewed (two of two recent admissions) verify the facility ensured the admission was timely and with dignity and respect, taking into account the family and residents' identified needs. One resident admission was into a shared room, which the resident and family both confirmed was managed with respect to both parties in the shared room and considered the privacy of each resident.

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The NM is interviewed. A record of those who have entry to service declined would be documented, however this rarely occurs due to all admissions (including private residents) being assessed prior to admission by the NASC service. There have been no instances when the facility's NM has had to decline entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Four residents' files are reviewed. All those reviewed have an interRAI assessment completed and an interRAI generated care plan developed by the NM. The care plan includes problems and goals, identified needs, and interventions in all service areas, including self-care needs, communication, mobility, social needs, including cultural and spiritual, nutrition, continence and behaviour needs.

A short term care plan has been developed if required for skin tears, wounds, mobility issues (falls) and infections (sighted).

Discussion with care staff and observation during the audit provide evidence that consultation with the RN relating to service provision occurs regularly. Care staff (interviewed) were observed consulting the care plan to verify the residents' care needs. Interview with one carer verifies she provides services reflective of the care plan content.

A handover is observed during the audit and confirms staff refer to handover notes as a reference and the content is consistent with the progress notes written for each shift (records sighted).

The facility has four general practitioners (GP) who visit the residents. One GP is interviewed and confirms the facility provides a high level of care and assessments and service provision are appropriate and in line with his recommendations.

Family contact occurs regularly, either verbally, by phone (progress notes sighted) or as part of the multidisciplinary team meeting process (six monthly).

Tracer 1 XXXXXX *This information has been deleted as it is specific to the health care of a resident*

The relevant ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e 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>

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

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

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

Attainment and Risk: FA

Evidence:

Prior to admission the NASC agency completes an interRAI assessment to ensure the placement is appropriate. The facility RN (interviewed) or the NM (interviewed) completes appropriate resident assessments (records sighted) on admission to the facility, including a pressure area risk assessment, falls risk assessment, continence assessment, and if required a wound assessment.

An InterRAI assessment is completed every six months (four of four files reviewed), and an updated care plan is generated based on the completed assessment. Those reviewed are completed in a timely manner by the NM. If an issue arises within the six months, an appropriate assessment tool is completed prior to the development of a short term care plan.

The ARRC requirements D16.2 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.)

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

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

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

Attainment and Risk: FA

Evidence:

Four residents' care plans are reviewed . The initial care plan is developed following an interRAI assessment and within timeframes to safely meet the resident's needs. The long term care plan is developed within three weeks of admission (records sighted including old notes). When progress alters, the RN (interviewed) or the NM (interviewed) will develop a short term care plan, using appropriate assessment tools.

Each interRAI generated care plan (sighted) is complete with interventions that reflect the resident's outcome goals (confirmed in resident and family interviews). There is evidence of integration from allied health in the care plans sighted. The clinicians' recommendations are included in the interventions (also confirmed at interview with the NM).

One care staff interviewed confirms the care plans are easy to follow and is able to describe interventions reflective of the care plan.

The relevant ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA
Evidence:
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.

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

Attainment and Risk: FA
Evidence: <p>The facility's NM (interviewed) documents appropriate interventions on the resident's interRAI assessment from which a care plan is generated. Those sighted are consistent with meeting the resident's identified outcomes, are evaluated regularly and the care plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents (for example, assistance with mobility) reflective of the resident's care plan.</p> <p>GP assessments sighted are detailed in the appropriate clinical form in the integrated resident's file and the subsequent intervention (antibiotic for urinary infection and pain management for an injured shoulder) are included on the resident's short term care plan (sighted).</p> <p>Residents and family interviewed confirm service delivery is consistent with meeting the residents' desired outcomes and they are involved in the review process, as evidenced in the residents' multidisciplinary team meetings (records sighted).</p> <p>The relevant 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>

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

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

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

Attainment and Risk: PA Low
Evidence: <p>A policy document on activities and how these will be delivered is sighted. Activities related forms associated with the policy include an activities assessment form, programme outline and attendance list, individual plan, an evaluation record and a form for social history.</p> <p>A monthly group activities programme is developed and provided by the activities person (interviewed) and includes: housie, piano and sing-a-long, mat bowls, exercises, word games scrabble, quoits, musical bingo, and church services once a fortnight, shared by three separate denominations.</p> <p>The individual activity plans reviewed do not reflect the resident's current interests and social activity and are not regularly reviewed: this requires improvement.</p>

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: PA Low
Evidence: <p>A monthly group activities programme is developed and provided by the activities person (interviewed) and includes: housie, piano and sing-a-long, mat bowls, exercises, word games scrabble, quoits, musical bingo, and church services once a fortnight, shared by three separate denominations.</p> <p>Individual activity plans reviewed do not reflect the resident's current interests and social activity, for example one resident who visits her family weekly, prunes the roses,</p>

attends to her potted plants and is actively attends political meetings monthly, does not have this included on her activity plan. Goals are not specific to the activity and are generalised, for example, goals include “maintain participation” or “maintain interest” and of those reviewed only one has been evaluated, and this was in July 2013.

Finding:

Individual activity plans reviewed do not reflect the resident’s current interests and social activity, for example one resident who visits her family weekly, prunes the roses, attends to her potted plants and is actively attends political meetings monthly, does not have this included on her activity plan. Goals are not specific to the activity and are generalised, for example, goals include “maintain participation” or “maintain interest” and of those reviewed only one has been evaluated, and this was in July 2013.

Corrective Action:

Activity plans include activities that are meaningful to the resident, include goals and are evaluated at least six monthly.

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

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

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

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

Attainment and Risk: FA

Evidence:

Four resident integrated files reviewed are evaluated on the interRAI assessment tool, which generates and updates the care plan. The facility's NM completes the interRAI care plan evaluations. The facility also evaluates residents’ care if progress is less than expected using appropriate assessment tools and a short term plan is developed to reflect the residents' changed needs. Residents and family interviewed verify they are included in care plan evaluations as part of the multidisciplinary process (records sighted) and there is evidence of this also documented in the residents' integrated notes (sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans when needs change.

The ARRC requirements D16.3c; D16.3d; D16.4a are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <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>

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

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

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

Attainment and Risk: FA
Evidence:
Four residents' integrated files are reviewed the NM and the RN is interviewed. Two of two files reviewed had evidence of referral to other health and disability services. For example, two external clinician referrals are initiated when a resident has increased needs (records sighted). Referrals are included in the integrated notes (sighted).
The NM (interviewed) confirms that, if required, the facility will accompany residents on appointments if the family member is unavailable.
Family and residents (interviewed) provide examples of input from other health and disability services including CDHB outpatient services, and the district nursing service.

The ARRC requirements D16.4c; D16.4d; D20.4 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

One file of a discharged resident is reviewed. The NM and RN are interviewed and verify all discharges include the involvement of the resident, family and GP. A discharge form is completed (sighted) and details any persons involved, any risks and measures to minimise the risk. The file reviewed is completed with evidence of family and GP involvement prior to the discharge, and ensuring the residents' medications are available post discharge.

The ARRC requirements D21 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.

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

Attainment and Risk: FA
Evidence: <p>Medicines safety management protocols and medication administration policy and procedure documentation are sighted. These detail residents' rights in relation to medicines, allergies, custody and storage, medication errors, antibiotic use, medicine check-in, disposal, short term and pro re nata (prn) medicines, standing orders, non-prescribed approved medication, self-medicating, reconciliation, controlled medicines, pain management, protocol and agreement for supplying medicines and staff competency check forms. The medication administration procedure provides instructions for the administration of a range of types of medicines and types of administration including warfarin, injections, nebulisers and pill crushing, for example.</p> <p>The facility has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the RN or the NM (records sighted). Discontinued medications are held in a container and to the pharmacy weekly when the new blister packs arrive, including controlled medications (records signed by the NM and the pharmacist sighted).</p> <p>The resident's prescription medication record is completed by the resident's GP, and administered by the facility care staff. A carer is observed administering medications on the day of audit (medication competency sighted). Records sighted are complete and meet medication guidelines.</p> <p>The medication trolley holds all current medication, blister packs and medication records and is locked when not in use and stored in the key pad secured medication cupboard.</p> <p>Controlled drugs are reviewed and storage is in line with guidelines. There are no fridge medications currently, however there is an appropriate storage area available should these require storage (observed).</p>

Eight medication files are reviewed. PRN medication is recorded to a level of detail to indicate the intended use.

There are no residents who self-medicate, although there are policies and procedures in place should this occur.

The ARRC requirements D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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 1.3.12.5 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: PA Low

Evidence:

The food service manual describes the prevention of kitchen cross-infection, leftover food, thawing of frozen food, dishwasher and sterilisation, pest control and storage of chemicals. This is reflected in observed practice.

A nutritional audit of the menus has been undertaken by a dietitian in July 2013 (sighted). The menu content on the day of the audit reflects the version in use by the facility. The menu is altered if the required food stock is unavailable, however the dietitian's recommendations regarding the inclusion of fruit and milk based portions and other recommendations regarding documenting afternoon tea and supper baking is not occurring and these require improvement.

Dietary profiles are written on admission (four of four files sighted), include likes and dislikes, preferences for beverages, and any other special dietary instructions. The RN or NM will inform the kitchen if there are any changes in dietary requirements. Residents' preferences are listed and catered for (verified in resident and family interviews).

Residents and family members interviewed also confirm there is variety in the food provided and it is sufficient and meets their needs. There are no weight issues with residents, and observation of meal service confirms residents enjoy the meal provided.

Meals are prepared and cooked overnight and then completed by the kitchen staff (interviewed). The RN works occasional night shifts, however does not have the required food and safety training requirements and this requires improvement. Food and fridge temperatures are recorded and those reviewed are within recommended guidelines.

The purchase of food is consistent with menu requirements (sighted), food waste audits are completed monthly (sighted), waste bins are kept covered and emptied after each meal (observed). Storage areas are clean and well maintained; however there are observed opened products in the freezers that are not dated and this also requires improvement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.13.5 (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: PA Low

Evidence:

The menu is altered if the required food stock is unavailable, however implementation of the dietitian's recommendations regarding the inclusion of fruit and milk based portions does not always occur. Implementation of other recommendations regarding documenting afternoon tea and supper baking are also not occurring. The registered nurse works occasional night shifts, however does not have the food and safety training requirements. There are observed opened products in the freezer that are not dated or labelled.

Finding:

The menu is altered if the required food stock is unavailable, however implementation of the dietitian's recommendations regarding the inclusion of fruit and milk based portions does not always occur. Implementation of other recommendations regarding documenting afternoon tea and supper baking is also not occurring. The registered nurse works occasional night shift, however does not have the food and safety training requirements. There are observed opened products in the freezer that are not dated or labelled.

Corrective Action:

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

A range of policies and procedures on the management of waste are in place. These include the management of spills of body substances, medical waste, blood accidents and guidelines for the use of personal protective equipment for staff. Practice is consistent with documentation.

General rubbish is placed into plastic bags that line rubbish bins in residents' rooms. Recycling and general rubbish are collected weekly by the local authority. Used continence products are disposed into paper bags and collected by a private contractor.

Cleaning chemicals are stored in a locked cleaning equipment and products cupboard in the hallway. Laundry chemicals are in a locked cupboard in the laundry and those for the kitchen/dishwasher are behind a locked door. A recent update on managing these chemicals has been delivered to staff by the company who provides them (records sighted) and the management of these is in the hazard and risk documentation. Information sheets on the products are available (sighted).

Personal protective equipment of face masks, goggles, plastic gloves, plastic aprons and over-shoe leggings are available and staff are using them (sighted).

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.

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

Attainment and Risk: FA

Evidence:

The building warrant of fitness is on display and expires 1 July 2014. Electrical checks have been completed within the required timeframe and tagged equipment and records are sighted.

Checks are being made on medical equipment; however this is not occurring according to best practice and has been raised as an area for improvement under criterion 1.1.8.1.

Three access ramps are at entrances to the building. A set of steps from the laundry area is not used by residents. Once inside, all areas where residents mobilise are level. Although all current residents are independently mobile, eight of them use a walking frame and are mobilising around the building. The risk of residents falling is noted in the risk management plan and actions to mitigate the risks are outlined. Similarly, these are detailed in individual care plans when relevant.

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

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

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

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.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are adequate toilet and shower facilities, which is confirmed by two residents during conversation. Four toilets are available for residents' use. All have handrails in situ and there are raised toilet seats in two. The six single rooms have hand basins in them; one of the three shared rooms has one and two are in the hallway for hand washing. There are two showers, one of which has a stool and another has a chair. Soft soap and hand sanitiser are available throughout the facility.

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

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

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

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

Attainment and Risk: FA

Evidence:

Six single rooms are used by residents. Three are larger and have a small sitting area attached. The remaining six residents are accommodated in three shared rooms of two beds. The manager confirms that residents are informed prior to admission of whether single or double rooms are available for occupancy and that if they come into a

shared room a priority process is used when a single one becomes available. One person who previously shared a room expresses satisfaction of moving into a single room when one became available but said she had been happy to share in the interim just to be at Methven House. She confirmed she had been given a choice on admission.

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.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: There is a communal dining area and a separate communal lounge. One end of the lounge can be closed off for visitors or instances when additional privacy may be required and the manager informs of examples when this has occurred. Activities are undertaken in one or other of these larger communal rooms. Both areas are fully accessible and within easy reach of all current residents.

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.

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

Attainment and Risk: FA
Evidence: <p>A laundry services manual sits within the quality procedure manual. This describes the features of and the management of the laundry design, clean and dirty linen, laundry equipment, chemical, good staff practice, infection issues and related work injuries.</p> <p>A separate document on cleaning services has clear objectives, includes the cleaner’s job description, the duty schedule and cleaning methods for different areas, safety. Infection control, maintenance, confidentiality and notes actions to take in the event of a work related injury.</p> <p>Bed linen and towels are placed in laundry bags and laundered off site at a local laundry. This is taken to the laundry by the Methven House staff, who will also collect a full clean bag. The laundry will deliver if the clean linen is not ready. Residents’ clothes are laundered at the small on site laundry by a caregiver on that shift. A dirty to clean process is used and a line on the floor acts as a reminder of this process to staff. According to the manager, soiled linen is managed according to the hazard management instructions.</p> <p>A person who also works in the kitchen is dedicated for cleaning and kitchen duties on the roster and undertakes these according to the schedule. This schedule has been worked out with infection prevention and control considerations in mind. Laundry and cleaning processes were included in the internal audits undertaken in January and February of this year and reports are sighted. There are no issues of concern identified.</p>

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

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

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

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

Attainment and Risk: FA

Evidence:

All staff undertake a trial fire evacuation and fire and emergency training during their orientation and are required to review this annually. This is completed at one of the monthly staff meetings. Policies and procedures for the prevention and management of fire safety and different types of emergencies are sighted. The fire evacuation plan has been approved by the Fire Service and the letter confirming this is sighted. The most recent six monthly fire evacuation trial is dated 20 February 2014 and the outcome faxed to the Fire Service.

Because of underground power lines, loss of power is reportedly rare. A butane cooker is available in the event of a power failure and for longer term outages, the local authority has agreed to supply a generator as it is considered to be a service providing 'special needs'. Emergency lighting is installed in the hallway and two bedrooms. Exit lights also illuminate automatically when the emergency lighting comes on. An emergency kit and a pandemic/isolation kit have been put together and these both have a list of contents. Bottled water is available with additional supplies available in a roof tank. The committee has provided the manager with a four wheel drive vehicle and if staff are unable to get to work because of snow, a committee member volunteers to pick them up. Methven House is on the local council's priority list for snow cleaning.

The policy on transportation and vehicle usage is sighted, as required in the ARRC agreement. This notes ways to protect the staff and resident.

A call bell system that is available in service areas and at each bedside is operational (same tested). The manager informs this is only audible in the kitchen at night, as that is where the caregiver is generally stationed. A display board indicating location of the call is sighted.

Staff and the manager inform the curtains are pulled across and the building locked at nightfall. The laundry is locked earlier. Residents say they feel very safe. Top windows may be opened in residents' rooms if ventilation is required at night. Visitors are encouraged to use a visitors' book so that staff are aware of who is in the building. Emergency numbers are in display in the manager's office.

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.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All rooms and areas used by the residents, except the hallway, have windows that can be opened to the fresh air. The building has a heat pump in the hallway at the doorway to the lounge and a separate one at the other end of the lounge. All residents' rooms have their own panel, or small electric heater, although one is currently away for repair. Despite the day being unseasonably cool the facility is warm. There are not currently any residents or staff who smoke, A designated sheltered external area for people who smoke is available if required.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint minimisation and safe practice policy and procedures include definitions of enablers, and the need for their use to be voluntary, as well as for the different types of restraint. These outline the service provider's philosophy, which notes their commitment to a restraint free environment and to provide the staff with good guidelines to enable them to prevent the need for restraint. The restraint policy documentation notes the circumstances under which restraint may be used, the ways in which the service will assess and monitor its use, relevant authorities and responsibilities around restraint, definitions of associated terminology including enablers, how the staff knowledge will be updated annually, considerations to be made prior to its use, guidelines for their use, and risk and quality management aspects.

Blank forms for the assessment and monitoring of disturbing behaviour, restraint/enabler pre-assessment, a restraint/enabler risk questionnaire, restraint evaluation, restraint/enabler register, a restraint/enabler review/evaluation, physical restraint/enabler consent, monitoring, staff competency questions and annual review of restraint use are all sighted. An information sheet for residents and relatives regarding restraint is also sighted.

A 'Management of Challenging Behaviour' policy and procedures sits alongside the restraint management documentation.

The audit visit confirms Methven House is a restraint free environment and that there are not currently any enablers or restraints being used. Education on restraint use and managing challenging behaviours is on the staff training schedule and staff report they are given additional guidance on the management of any resident with challenging behaviours when the need occurs (example sighted). During interview staff describe the voluntary nature of enablers.

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>Infection control policies and procedures define the responsibility for infection control; note the roles of relevant key stakeholders, state the programme is reviewed annually and that there will be regular in-service education for staff. The role of infection control in the quality and risk management programme is described and there is a position description for the infection control coordinator. Policies and procedures include one on residents with infections and one on staff with infections. These focus on methods of prevention of spread.</p> <p>There is an infection control (IC) programme that is reviewed annually (sighted) with clear lines of accountability and approved by the NM. All requirements of the IC standard are included. The facility has recently appointed the RN into the role of IC co-ordinator and she is supported during this transition by the NM. The NM (interviewed) and the IC RN</p>

(interviewed) form the IC team, and report every month to the management support meeting (records sighted), and an annual report to the board.

The facility's front entrance notice requests persons with flu not to visit and hand gel is available at the front door and throughout the facility for any visitor or resident to use. (Visitors are observed using the hand gel). If there are any internal infections, the facility has processes in place to prevent visitors and to isolate the infection.

The ARRC requirements D5.4e 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.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>The IC RN and NM (both are interviewed) oversee the IC programme with the NM providing support and clinical guidance in the initial stages of transition to this role, including collating data, documenting and auditing. The NM has previous IC experience (sighted) and the RN is enrolled for an IC training programme in May 2014 (application approval sighted).</p> <p>The IC RN documents resident specific IC information, including treatments and conclusions, reporting results to the management support meeting monthly (records sighted). The management support meeting consists of the chairman of board, a committee member, the NM and the RN. A report is also included in the agenda for monthly staff meetings (minutes sighted).</p> <p>Expert advice is gained from the Christchurch IC nurse specialist and residents' GPs as required for any resident infection (confirmed in GP interview). Residents and family interviewed verify they are advised of infection treatments. Observed throughout the facility is hand gel and soap dispensers and education on hand hygiene on walls above hand basin. The facility has an up to date outbreak kit (sighted). There have been no reported outbreaks.</p>

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

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

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

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

Attainment and Risk: FA
Evidence: There are a wide range of infection control related policies and procedures that are fit for purpose for Methven Home (sighted). Examples of these include precautions for infections that are airborne, droplet and contact transmission-based; pets and pest control, personal protective equipment, outbreak management, notifiable diseases and all others as listed in (a) to (i) of this criteria.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The NM has previous experience in IC and is working alongside the RN IC co-ordinator to provide on-going education for staff. The IC RN has no current IC experience but is attending A Bug Control programme 27 May 2014 (records sighted).

An annual IC training session is provided by an IC nurse specialist (records and content of session sighted). A notice at the front entrance and above communal hand basins provides visual aid in the correct hand hygiene methods (sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
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: PA Low
Evidence: <p>A policy and procedure document in the collection, collation and analysis of information on infections and the measurement of incidence using surveillance is sighted. This notes a monthly record of infections is made and an infection control report (form sighted) is to be completed. A form for the purpose of analysing the incidence of infections is in place.</p> <p>Infection control related definitions complement these documents, as does a set of guidelines for managing specific infections and for identifying six key infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections.</p> <p>Individual surveillance data are collected as it occurs and included on the monthly IC data evaluation sheet (sighted). Collection, collation and analysis of information on infections and the measurement of incidence using surveillance are sighted. IC surveillance identifies six key infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections.</p> <p>Evidence in the last two management support meeting minutes and staff meeting minutes verify that IC surveillance is occurring, however analyses, conclusions and specific recommendations to minimise reduction in infection have not been documented and this requires improvement.</p>

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: IC surveillance identifies six key infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections. Evidence in the last two management support meeting minutes and staff meeting minutes verify that IC surveillance is occurring, however analyses, conclusions and specific recommendations to minimise reduction in infection have not been documented.
Finding: Surveillance data is occurring, however analyses, conclusions and specific recommendations to minimise reduction in infection have not been documented.
Corrective Action: Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and managed in a timely manner.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)