# Age Care Central Limited - Marire

## Current Status: 19 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

Marire rest home provides rest home level care for up to 38 residents. On the day of audit, the facility had full occupancy. The service is managed by Age Care Central Ltd, which is a registered company as a charitable entity under the Charities Act. The chief executive officer (CEO) and three directors form the Board, which provide a governance role. Appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff.

The nurse manager is an experienced registered nurse with many years of experience in practice nursing, nursing education and managing aged care facilities. She is also supported by the rest home coordinator and the registered nurse.

The service is commended for achieving continual improvement ratings around food services and recognition of Maori beliefs and values. The audit identified improvement requiring around some aspects of care planning, medication management and preventative maintenance.

## Audit Summary as at 19 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 |
|  | 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 19 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

### Organisational Management as at 19 March 2014

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

### Continuum of Service Delivery as at 19 March 2014

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

### Safe and Appropriate Environment as at 19 March 2014

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

### Restraint Minimisation and Safe Practice as at 19 March 2014

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

### Infection Prevention and Control as at 19 March 2014

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

## Audit Results as at 19 March 2014

### Consumer Rights

The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care planning accommodates individual choices of residents and/or their family/whānau. Residents and relatives interviewed spoke very positively about care provided. Complaints processes are implemented, complaints, and concerns are actively managed and well documented. Marire is committed to ensuring that residents who identify as Māori to their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services. There are no residents at Marire that identify as Maori. Complaints processes are implemented, complaints, and concerns are actively managed and well documented.

### Organisational Management

There is a business plan 2012-2015 that includes mission statement, vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed and this includes key performance indicators and progress against goals. The quality management plan is implemented. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman. There is a nurse manager who oversees Maririe and Maryann rest home and hospital. She is supported by the rest home coordinator and the RN.

Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Most of the caregivers have completed a national qualification in care of the elderly. Human resource policies are implemented and there is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

### Continuum of Service Delivery

The service has a well-developed assessment process and resident’s needs are assessed prior to entry. There is a comprehensive information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurse in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate care. Risk assessment tools and monitoring forms are available. Service delivery plans are individualised. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. While the six resident files reviewed demonstrated holistic care overall, there are improvements required by the service around wound care documentation.

Marire employs a trained diversional therapist. Activities are planned and reviewed by the diversional therapist. There are several programmes planned that are meaningful and reflect ordinary patterns of life.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are improvements required around the medication management.

The service has employed a domestic services manager. There are food service policies, procedures, and a link to a dietitian. There is a compulsory education plan in place for all kitchen staff. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Resident’s individual preferences are acted upon. Residents, staff and family/whanau interviewed responded favourably to the food that is provided. A rating of continuous quality improvement has been awarded in recognition of improvements made to the nutrition and food services.

### Safe and Appropriate Environment

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation.

There are improvements required around some maintenance areas. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members.

Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

### Restraint Minimisation and Safe Practice

Marire remains restraint-free. There is one resident using bedrails as an enabler, and the resident signed the consent form for use of this. All required documentation for enabler use is recorded in the restraint folder and resident’s file. Staff receive training around restraint minimisation and enablers.

### Infection Prevention and Control

Marire has an established infection control programme. Infection control is a standing agenda item at the three monthly risk management meetings where all issues and infections are discussed with staff. All results and infection control matters are reported to the nurse manager on a monthly basis or sooner if there is an issue. She collates a monthly record of infections data and then a copy of these results is retained at the staff reading folder for staff to read and sign off. The registered nurse, the nurse manager and the resident's general practitioner are notified promptly of any positive pathology that is identified as an infection. Infection control programme is reviewed annually and most recently, the service purchased Bug Control Infection Prevention and Control Manual. Staff are well informed about infection control practices and reporting. Memos related to infection control issues are noted in the staff reading folder. All staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Age Care Central Limited |
| **Certificate name:** | Age Care Central Limited - Marire |

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

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| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Marire Rest Home |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 19 March 2014 | **End date:** | 20 March 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 38 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 7 |
| **Other Auditors** | XXXXX  | **Total hours on site** | 12 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 9 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 34 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 15 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Marire rest home provides rest home level care for up to 38 residents. On the day of audit, the facility had full occupancy. The service is managed by Age Care Central Ltd, which is a registered company as a charitable entity under the Charities Act. The chief executive officer (CEO) and three directors form the Board, which provide a governance role. Appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff. The nurse manager is an experienced registered nurse with many years of experience in practice nursing, nursing education and managing aged care facilities. She is also supported by the rest home coordinator and the registered nurse. The service is commended for achieving continual improvement ratings around food services and recognition of Maori beliefs and values. The audit identified improvement requiring around some aspects care planning, medication management and preventative maintenance.  |

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| **Outcome 1.1: Consumer Rights** |
| The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care planning accommodates individual choices of residents and/or their family/whānau. Residents and relatives interviewed spoke very positively about care provided. Complaints processes are implemented, complaints, and concerns are actively managed and well documented. Marire is committed to ensuring that residents who identify as Māori to their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services. There are no residents at Marire that identify as Maori. Complaints processes are implemented, complaints, and concerns are actively managed and well documented. |

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| **Outcome 1.2: Organisational Management** |
| There is a business plan 2012-2015 that includes mission statement, vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed and this includes key performance indicators and progress against goals. The quality management plan is implemented. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman. There is a nurse manager who oversees Maririe and Maryann Rest Home and hospital. She is supported by the rest home coordinator and the RN. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Most of the caregivers have completed a national qualification in care of elderly. Human resource policies are implemented and there is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a well-developed assessment process and resident’s needs are assessed prior to entry. There is a comprehensive information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurse in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate care. Risk assessment tools and monitoring forms are available. Service delivery plans are individualised. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. While the six resident files reviewed demonstrated holistic care overall, there are improvements required by the service around wound care documentation.Marire employs a trained diversional therapist. Activities are planned and reviewed by the diversional therapist. There are several programmes planned that are meaningful and reflect ordinary patterns of life. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are improvements required around the medication management. The service has employed a domestic services manager. There are food service policies, procedures, and a link to a dietitian. There is a compulsory education plan in place for all kitchen staff. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Resident’s individual preferences are acted upon. Residents, staff and family/whanau interviewed responded favourably to the food that is provided. A rating of continuous quality improvement has been awarded in recognition of improvements made to the nutrition and food services. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. There are improvements required around some maintenance areas. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility. Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Marire remains restraint-free. There is one resident using bedrails as an enabler, and the resident signed the consent form for use of this. All required documentation for enabler use is recorded in the restraint folder and resident’s file. Staff receive training around restraint minimisation and enablers.  |

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| **Outcome 3: Infection Prevention and Control** |
| Marire has an established infection control programme. Infection control is a standing agenda item at the three monthly risk management meetings where all issues and infections are discussed with staff. All results and infection control matters are reported to the nurse manager on a monthly basis or sooner if there is an issue. She collates a monthly record of infections data and then a copy of these results are retained at the staff reading folder for staff to read and sign off. The registered nurse, the nurse manager and the resident's general practitioner are notified promptly of any positive pathology that is identified as an infection. Infection control programme is reviewed annually and most recently, the service purchased Bug Control Infection Prevention and Control Manual. Staff are well informed about infection control practices and reporting. Memos related to infection control issues are noted in the staff reading folder. All staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme.  |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 2 | 40 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 2 | 88 | 0 | 2 | 1 | 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 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Three out of four wounds did not have an assessment, management plan or evaluation documentation completed. | Ensure wound care plans document a regular and on-going assessment, a management plan and progress/ evaluation of wound. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)In seven of twelve medication charts there was evidence of transcribing. (ii) When administering drugs the staff observed were checking the medication against the administration form and not the medication chart. | (i)Ensure that transcribing ceases. (ii) Ensure that when administering drugs staff giving medication should follow correct procedures and check medications against the medication chart prior to administration. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications  | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | The doors and doorways in all wings have large areas where the paint is peeling or where there are deep grooves and scratches. | Ensure doors and doorways are repainted. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.4: Recognition Of Māori Values And Beliefs | 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. | CI |  |
| HDS(C)S.2008 | Criterion 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. | CI | Several effort made to ensure that Maori consumers have access to appropriate services. These include but not limited to: (i) The service developed Maori Health Plan that identifies the needs of the region. Maori Health Plan was approved by the directors of the board. The Maori Heath Plan also includes Maori Health Priorities Action Plan and has 10 objectives around staff preparedness and improving access to services for Maori. The CEO advised that the plan will be reviewed in June 2014. (ii) There is also a Maori Health Policy that refers to Te Kawau Maro, Taranaki Maori Health Strategy 2009 to 2029. (iii) Nurse manager obtained a qualification around Maori history and understanding of Maori culture. (iv) CEO is Kaumataua. (v) Branding of organisation as Aged Care Central Ltd includes Maori themes. (vi) The organisation structure also includes cultural and spiritual advisors of Maori. (vii) A large print of the code is displayed at the front of entrance and it is in Maori. (viii) An interview with a cultural adviser confirmed that individual needs of Maori are understood, and gave examples of how their individual needs were met in the past. For example, a space is provided for family gatherings to take place. (ix) The RN is supported by the clinical coordinators and the RN team from the Maryann home and hospital. They have PDRP portfolios that include competencies around Treaty and Waitangi.  |
| 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.  | CI |  |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | On admission residents have a nutritional profile, developed by the registered nurse, which identifies dietary requirements, likes and dislikes, food preferences including cultural preferences. This information is relayed to the kitchen. When there are any changes to resident’s dietary needs or physical abilities that may require the use of special equipment or a modification of diet these needs are communicated to the cook. Special diets are noted in the kitchen, which is able to be viewed only by kitchen staff. At present special diets being catered for include diabetic diets, and one resident on a gluten free diet. The resident on a gluten free diet confirms her needs are being met. The cook on interview was able to identify those requiring special diets and residents likes and dislikes. She states that there are always alternatives offered to residents who dislike the menu choice of the day. This was confirmed by residents interviewed. A special meal request for residents and family policy was added to the food services manual in January 2014. This was an initiative to provide for residents who have a sudden change in health status and to accommodate family who may be staying with them. It states that the cook needs 20 – 30 minutes to accommodate. The cook confirmed this was adequate notice. A size of meals survey was conducted in May 2013. This included likes and dislikes. This was collated and feedback was provided to the dietitian and the cooks. Changes to the menu and portion sizes were introduced following feedback from a residents meeting held on 20-May-13. Minutes of the meeting and a Quality Deficit Report detailing corrective action and sign off were sighted. An internal food handling audit was conducted in June 2013. Issues were identified and discussed at the risk management meeting. Recommendations made and signed off when completed. There is a summer and winter menu on a four weekly cycle which is designed and reviewed by a registered dietician on a two yearly basis. The service from this year has implemented an annual menu review. At the last review the dietitian recommended that there be more fruit at lunch and for the use of fortified milk. These recommendations have been implemented. The domestic service manager has implemented a project day for cooks every fortnight that allows for education, meetings and training. The last service day the dietitian gave a presentation on weight loss, purees and soft diets, vegetarian diets and the needs of those with dementia. Evaluation of the day was very positive.Residents have a choice of having breakfast in the dining room or having a tray delivered to their room. Midday meals and evening meals are served in the dining room unless a request for a tray is received. On day one of the audit both auditors witnessed the midday meal. The menu was advertised on a display board directly outside the dining room. The tables were laid nicely with the appropriate utensils and serviettes. The food was attractively presented on the plates. Salt and pepper were available on each table. Drinks were available. It was a homelike atmosphere with residents chatting amongst themselves or with the staff. Staff was courteous and unobtrusive and residents were not hurried. On interview with staff, residents and family/whanau all commented on how good the meals were. Positive comments on meals was evidenced in resident meeting minutes and included comments such as “good service” and “my suggestions have been followed up”.  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Caregivers, the registered nurse (RN) and management interviews demonstrate an awareness of consumers' rights and obligations. Specific examples were given by the three caregivers interviewed that support their understanding of the Code of Rights. Observations of staff and residents interaction during the audit provided examples of ways residents' rights are upheld by staff. Resident (five) and family (four) interviews confirm that the service functions in a way that complies with the code of rights.  |

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

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

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

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

Consumers are informed of their rights.

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

|  |
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| **Attainment and Risk:** FA |
| **Evidence:** |
| Large print of Health and Disability Code of Rights posters are on the walls in the entrance. Code of rights leaflets are also available at the front entrance of the service. The information pack for new residents/families on entry includes information about the code of rights. The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, the registered nurse discusses the information pack with the resident and their family/whanau. This includes the code of rights, complaints and advocacy information. Discussions with four family members identified that they are well informed about the code of rights and access to advocacy services. Marire home provides an open-door policy for concerns or complaints. Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. This information is also provided prior to entry to the service as part of the information booklet. Discussions with three caregivers identified that they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff have received training on respecting the resident's privacy, dignity and independence. Residents reported they are treated respectfully, and their privacy is not compromised. Staff are observed respecting the privacy of residents and promoting their independence in activities of daily living. A privacy policy is implemented. Caregivers interviewed stated that residents’ personal effects are kept in their rooms and personal clothing and property is not shared. There was no intrusive noise noted during the audit. Staff members are observed requesting permission before entering resident’s rooms, and being respectful of the residents' privacy. On interview, five residents interviewed confirmed that their personal privacy is respected by staff.Residents’ cultural, spiritual and social needs are identified on admission and included in service planning and delivery; this is sighted in all six files reviewed. All five residents interviewed confirmed that they are consulted, and have choice in their care provision and activities of daily living. As observed, independence is encouraged by the staff and the physical environment places no constraints on independence. The service has a comprehensive policy on abuse and neglect and this is included in the staff orientation and education programme. Staff/resident interaction was observed to be appropriate during the audit. Three caregivers and one RN interviewed are aware of the types of abuse and neglect and their responsibilities in reporting any concerns. Resident and relatives interviewed stated they had not seen any episodes of abuse or neglect and that staff are respectful.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Maori health guidelines are in place to support Maori residents and whanau. The guidelines for provision of culturally safe services included in Marire home bi-cultural statement. Documentation around the role of the Maori advisor identify cultural needs for Maori. Staff receive training in cultural safety, which assists in identifying and eliminating barriers within their control. The importance of whanau is identified in the policy. The service has a linkage to a local Maori advisor. There are no Maori residents who identify specific needs or who identify as being of Maori ethnicity currently. Staff interviewed described how they cared for a Maori resident in the past. Marire have relationships with Maori Women’s Welfare League, Ngati Ruanui Tahuna and Tui Ora Maori Services.  |

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Document review and interview with management and the staff confirm that Marire is committed to ensuring that residents’ who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services.  |
| **Finding:** |
| Several effort made to ensure that Maori consumers have access to appropriate services. These include but not limited to: (i) The service developed Maori Health Plan that identifies the needs of the region. Maori Health Plan was approved by the directors of the board. The Maori Heath Plan also includes Maori Health Priorities Action Plan and has 10 objectives around staff preparedness and improving access to services for Maori. The CEO advised that the plan will be reviewed in June 2014. (ii) There is also a Maori Health Policy that refers to Te Kawau Maro, Taranaki Maori Health Strategy 2009 to 2029. (iii) Nurse manager obtained a qualification around Maori history and understanding of Maori culture. (iv) CEO is Kaumataua. (v) Branding of organisation as Aged Care Central Ltd includes Maori themes. (vi) The organisation structure also includes cultural and spiritual advisors of Maori. (vii) A large print of the code is displayed at the front of entrance and it is in Maori. (viii) An interview with a cultural adviser confirmed that individual needs of Maori are understood, and gave examples of how their individual needs were met in the past. For example, a space is provided for family gatherings to take place. (ix) The RN is supported by the clinical coordinators and the RN team from the Maryann home and hospital. They have PDRP portfolios that include competencies around Treaty and Waitangi.  |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Cultural values and beliefs are identified through the admission process. Family/whanau involvement is actively encouraged through all stages of service delivery.Links are established with disability and other community representative groups as directed/requested by the resident/whanau. The facility recognises cultural occasions/practices, and this is noted in all six files reviewed. Discussions with four relatives all identified that values and beliefs were considered. Discussion with five residents all stated that staff took into account their culture and values. ACE training covers cultural awareness and nine out of 12 caregivers have a national qualification in care of elderly. Cultural safety policies and Maori Health Plan reflect culturally safe practices and access to appropriate expertise e.g. cultural advisors.Care plans include cultural values & beliefs desired outcome or goal. Care plans document support and interventions to meet the resident’s needs, individual preferences and chosen lifestyles. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Marire has clear policies and house rules on professional standards and the conduct expected of staff. Staff interviewed were aware of maintaining professional boundaries and stated that they would report any breaches if this was evidenced.Staff are made aware of the code of conduct at induction. There are house rules in the collective and individual agreements.Any concerns with professional boundaries are raised at the caregiver forums.The nurse manager stated that complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. A review of the accident/incident reporting system and staff interview indicates there have been no staff infringements involving professional misconduct.Job descriptions detail professional responsibilities and boundaries. Performance reviews are used for monitoring individual staff adherence to professional standards. Enrolled nurses work under the direction and supervision of registered nurses. Resident and family interview confirms no incidences of discrimination, coercion, harassment, sexual, financial or, other exploitation. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001.Staff communication is maintained and kept up to date verbal handovers, written handovers, and memos, reading folders, diaries, e mails and regular team meetings. Policies and procedures are implemented. Staff performance objectives are documented; staff education, competency checks and appraisals are conducted. A quality monitoring programme is implemented and this monitors contractual and HDSS standards compliance, and the quality of service delivery. The internal audit schedule is implemented and consumer surveys are conducted. Five residents and four family members interviewed spoke very positively about the care provided.There is good communication with Maryann RN’s for telephone triage, advice and backup in emergency is maintained. There are two enrolled nurses, which provide additional support to the RN. She is also supported by the clinical coordinators from Maryann. D1.3 All approved service standards are adhered to.D17.7c There are implemented competencies for all staff including caregivers, and qualified staff. There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a policy on open disclosure. Information about the code of rights is made available to the residents and family /whanau through the information packs, complaints procedure and pamphlets on advocacy. The code is clearly displayed at the entrance to the facility.There is an interpreter and translation services policy that identifies local access to interpreter and relevant community services.D11.3 The information pack is available and advised that this can be read to residents.There are no residents requiring access to an interpreter and any Maori residents can and are supported by the Maori cultural advisor.D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The rest home coordinator confirmed that the private paying resident currently in the rest home had been informed of arrangements for subsidies if they wished to pursue this.D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.D16.4b Four relatives stated that they are always informed in a timely manner when their family members health status changes.There are individual resident family/whanau forms and these record any contact made with family/whanau. Seven of nine incident and accident forms reviewed showed that following of an event families are notified. Two of the incident, the resident gave instructions to staff not to contact the family members. This is recorded on the incident and accident form. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families/whanau on admission. This is also discussed with residents and their families during the admission process.Three caregivers interviewed are familiar with the code of rights and informed consent when delivering resident cares and that consents are sought in the delivery of personal cares. This is confirmed by five residents. Code of rights and informed choice training completed February 2014. A sample of six resident files included signed consents for medications, to be transported to outings, sharing and storage of information, and to take photograph for the purpose of health information. There is a policy on advanced directive, which clearly includes who may sign the advance directive. All advanced directive sighted were signed by the resident. Four family/whanau and four residents were aware of advocacy services and how to access the service. All caregivers interviewed confirmed the process for advocacy. D3.1.d: Discussion with four family/whanau members identifies that the service actively involves them in decisions that affect their relative’s lives. D13.1: There were six of six signed admission agreements. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information on access to advocacy services is provided to residents and relatives on admission. Advocacy training is included in the code of right training and last provided in January 2014. Staff are conversant with the residents' right to advocacy and support services.The advocacy pamphlet is available along with the code of rights pamphlet and the elder abuse and neglect prevention service pamphlets at the entrance to the service. D4.1e; The resident file includes information on residents family/whanau and chosen social networks with details of any contacts documented in the family/whanau contact sheet. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Marire does not have specified visiting hours, allowing family/whanau to visit the facility at any time they wish. D3.1.e Discussion with staff and four relatives confirmed that they are supported and encouraged to remain involved in the community and external groups visit as part of the activity programme. Marire have visiting groups that visit regularly. Residents are encouraged to maintain familiar links with outside groups, such as churches and service organisations. Regular church services are held for those residents who wish to attend. Entertainers are employed to visit for regular activities.There are no restrictions on visiting, taking residents for outings. A space is provided for family gatherings to take place, and Marire encourages the celebration of special occasions. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a complaints procedure that complies with Right 10 of the Code and complaints information is provided to residents and relatives. The nurse manager is responsible for ensuring all complaints are fully documented and thoroughly investigated. There is a complaints register, which is up to date and includes relevant information regarding the complaint. The complaint register includes six complaints 2014 to date. Documentation including follow up letters and resolution demonstrate that complaints are well managed. Verbal complaints are also included that identify actions and response. Resident and family interview confirmed that they are aware of how to make a complaint.  |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is managed by Age Care Central Ltd (ACL), which is a registered company as a charitable entity under the Charities Act. ACL is a company formed to manage the operations of Maryann rest home and hospital and Marire rest home. The chief executive officer (CEO) and three directors form the Board, which undertakes a governance role. There is a business plan 2012-2015 that includes a mission statement, and vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed 30 November 2013 and this includes key performance indicators and progress against goals. There is an organisation quality management plan 2014-2015 which includes marketing and publicity, human resources, consumer rights, restraint minimisation and safe practice, medicine management, clinical management, diversional therapy, document control, housekeeping, food services, health and safety and infection control. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman. There is a nurse manager who manages both facilities. She is supported by the registered nurse who works 24 hours a week at Marire. There is also domestic services manager who is responsible of managing non-clinical side of the business at both sites.Marire rest home provides care for up to 38 residents at rest home level care. At the time of audit, occupancy is at full capacity.D15.3d: The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The nurse manager was appointed to her role in April 2013 who is an experienced NZRN. She has worked as a practise nurse for eight years, a district nurse for nine years and as a nurse tutor for 12 years. She was running another aged care facility in Levin prior to this role.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the nurse manager who has clinical oversight for both Marire and Maryann, the RN fulfils the role at Marire. She is supported by the CEO in non-clinical matters and clinical coordinators from Maryann rest home and hospital on clinical issues.  |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Marire rest home implements its quality and risk management system. Key components of the quality system link to service delivery. Quality data is reported at the risk management meetings and discussions with the RN and three caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. Caregiver’s forum includes discussions relating to the components of the quality and risk activities. Resident meetings are held four times a year and minutes are maintained. Resident survey was last completed in 2013, which shows satisfaction with the services provided. There are combined management, health and safety, RNs meetings, food services meeting, housekeeping and maintenance meetings with Maryanne home and hospital. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, education, quality activities, policies and procedures and general business. Minutes are maintained and kept in the staff reading folder as well as meeting minutes’ folder. Audits are completed by the nurse manager and non–clinical audits are completed by the domestic services manager. There is evidence of quality improvement plans/action plans being developed when quality activities such as internal audits, quality deficit reports and satisfaction surveys identify areas for improvement. Example: issues identified during resident file review identified that some part of the care plans were not fully completed. This was reported as a quality deficit and followed up by the registered nurse and the care plan updated. Another quality deficit report around infection control issue during laundry service also led to staff training. Audit results are displayed in the staff readings folder and read and signed off by the staff members. Audit results are also discussed in the staff meetings. There is a document control system. All policies include the date the policy was last reviewed. Documents no longer relevant to the service are removed and archived. Discussion with three caregivers and the registered nurse identified that staff are familiar with the policies and procedures. There are implemented health and safety policies that include hazard identification. Domestic services manager is the health and safety officer. A review of the documentation indicates that maintenance issues and hazards are resolved promptly. Hazard register is up to date and the last review was completed on February 2014. Review of hazard register shows that new hazards are identified and required corrective actions are implemented. Such as high temperature readings were reported following a routine checks. This resulted in adjustment in tempering valves. More frequent checking has are completed and recorded and subsequently tempering valves are replaced. There is an annual staff training programme that is implemented. Nine out of 12 staff has a national qualification in care of elderly. D5.4: The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning.Security and safety policies and procedures are in place to ensure that a safe environment is provided. Emergency plans ensure appropriate response in an emergency.There are infection control policies and procedure and a restraint policy and health and safety policies and procedures.D19.2g: Falls prevention strategies are in place that include, the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff complete the incident and accident forms and the RN on duty undertakes an initial assessment and completes the relevant part of the form. Incident and accidents are investigated by the registered nurse or the nurse manager. There is a known process for the reporting and investigation of incidents. Caregiver interview confirmed this. Incidents/accidents and near misses are investigated and a log of incidents occurs monthly. There is a discussion of incidents/accidents in monthly risk management meetings. Staff and resident incident accident forms are recorded separately.Nine incident reports were reviewed and in all instances, there is registered nurse assessment following the incident. Appropriate interventions were followed-up in the short term or long term care plans. Memos and written handover notes include alerts around change of interventions following an incident. The service is responsive to individual trends. Incident reports reviewed showed that falls assessment re-completed following the incident of falls. The score confirmed the resident is high falls risk and required interventions are made. Medical notes also showed GP follow up following these incidences. Monthly reporting includes incident and accidents, time, injuries, outcome and preventable actions.D19.3c Discussions with the nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are job descriptions for each position and appropriate human resource policies/procedures are implemented including staff recruitment and support. Staff orientation programme is established and implemented. Staff performance appraisals are completed at least yearly. Enrolled nurses work under delegated authority of the RN. The nurse manager plans and coordinates training both internal and external. Training plans developed for in-service with sessions held throughout the year applicable to the services provided. The registered nurse interview and her personal file review confirm that she had completed several external training such as pressure area care, arthritis, first aid, oral health, Huntington disease, leadership, communication and staff management. Nine out of 12 caregivers have a national qualification in care of elderly. An annual training plan is implemented and individual staff training records are maintained.Seven staff files were reviewed (a registered nurse, one enrolled nurse, the rest home coordinator, two caregivers, and one kitchen assistant, and one house keeper). Reference checks are completed before employment. Staff files sampled have current performance reviews. The kitchen assistant training records include, food handling trainings, hand hygiene and a training day provided by dietitian. This training include subjects around nutrition and weight loss in elderly. Orientation checklists are evident in all staff files reviewed. Annual practicing certificates were sighted for registered nurses, enrolled nurses and general practitioners.D17.8 Eight hours of staff development or in-service education has been provided annually. Three caregivers interviewed, states they all had the national certificate in care of the elderly. There are implemented competencies for staff related to medication with all relevant caregivers. The registered nurse, enrolled nurses and GP's have current practicing certificates.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a staffing policy, which provides the documented rationale for staffing, and skill mixes. There are a total of 34 staff. The nurse manager works at both Marire rest home and Maryann. The rosters evidence that the nurse manager is on duty in Marire rest home at least two days per week and is available on call. The rest home coordinator (a senior caregiver) works Monday-Friday and provides on call cover with registered nurse support. There is a registered nurse on duty at least three days per week and an enrolled nurse is on duty nine days fortnightly. There are three caregivers on duty each morning. There is an enrolled nurse or senior team leader on duty in the afternoons with two caregivers. At night, there are two caregivers on duty. Interviews with the registered nurse, three caregivers, five residents and four family members identify that staffing is adequate to meet the needs of residents. The registered nurse reported that peer support is available from Maryann home and hospital. The RN and the nurse manager are available on call. Marire rest home also employs one diversional therapist, two enrolled nurses, one cook and four cook assistants, five staff in household, one administrator and one maintenance person. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident records are integrated and managed in line with contractual and legislative requirements. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time and includes resident/family/EPOA input. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in the nurse’s office. Care plans and notes are legible and where necessary signed by the registered nurse. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry. D7.1 entries are legible, dates and signed by the relevant caregiver or registered nurse including designation. Individual resident files kept demonstrate service integration including GP, allied health professionals and specialists involved in the care of the resident.  |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to Marire potential residents, have a needs assessment, completed by the community services co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for resident’s families/whanau at entry. The information pack includes relevant aspects of service and residents and/or family/whanau are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. There is an admission procedure in place and admission documentation, which includes resident and next of kin details. The registered nurse on duty completes all the admission documentation and relevant notifications of entry to the service. The registered nurse interviewed was able to describe the entry and admission process. The GP is notified of the new admission. Signed admission agreements sighted. Five residents and four family/whanau confirm they received the information pack.D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.D 14.1: Exclusions from the service are included in the admission agreement.  |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a declining entry policy. The service records the reason for declining service entry to residents should this occurs and communicates this to residents/family/whānau. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.2, 3, 4: Six files reviewed identified that an initial nursing assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Six of six care plans evidenced evaluations completed at least six monthly. Activity assessment and the activities care plans have been completed by the diversional therapist. Five residents interviewed stated that they and/or their family/whanau were involved in planning their care and at evaluation. Resident files reviewed included family/whanau contact records, which were completed in all resident files sampled. D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. More frequent GP review was evidenced as occurring on review of residents with acute conditions. A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment (Coombes) b) pressure area risk assessment (Waterlow), c) continence assessment (and diary), d) skin assessment and pain assessment.Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Six files reviewed identified integration of allied health and a team approach is evident. The GP interviewed spoke very highly about the service and describes good communication between the registered nurse, rest home coordinator, GP and surgery. Resident files reviewed included; one resident identified with a wound, one resident requiring the use of controlled medication, one resident with disturbing behaviour, one resident with stroke and depression, one resident suffering frequent falls and one resident with diabetes.Tracer Methodology: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The initial nursing assessment and care plan is completed within 24 hours of admission and the long term care plan is completed within three weeks. Admission documentation obtained includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. They are evaluated at least six monthly by a registered nurse. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment and the first resident care plan within the required timeframes. All resident files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission. Assessments are conducted in an appropriate and private manner. Relatives/whanau and residents advised on interview that assessments were completed in the privacy of their room. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Family/whanau members (four) and five residents interviewed are very satisfied with the support provided. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term care plan from information gathered over the first three weeks of admission. There is evidence a holistic approach to care planning with resident and family/whanau input ensuring a resident focussed approach to the whole process. There is evidence of six monthly review and evaluation, which is signed by a registered nurse.This is supported by other allied health care professionals providing input such as physiotherapist, mental health of the older person service, dietitian and podiatrist. The integrated resident file also contains admission documents, informed consent forms, care documents, risk assessment tools and reviews, medical documentation, test results (laboratory and radiology), allied health notes, referrals and other relevant health information, associated assessments such as activities, behavioural, recordings (weight, blood pressure), incidents and accidents and any correspondence. Acute care plans were in place with interventions, management and evaluations. All were signed off when resolved.All six resident files reviewed identified that family/whanau were involved. Five out of five family/whanau advised on interview that they were involved in the development of the care plan and were kept well informed of changes to care or health status and support by staff is consistent with their expectations. Notes by the GP and allied health professionals are evidenced. D16.3f: Six resident files reviewed identified that family/whanau were involved.D16.3k: Short-term care plans are in use for changes in health status. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Six resident files were reviewed. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, and registered nurses. A review of acute term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews for residents and more often if required. The registered nurse/rest home coordinator are responsible for the education programme and ensure all staff has the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers on each shift as evidenced in all six residents' progress notes sighted. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, pressure mattresses, hoists, wheelchairs, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Residents’ weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated. All falls are reported on the resident accident/incident form. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. Pain monitoring, using a pain scale tool, is carried out for those on regular and prn pain relief including pre and post medication administration. Five out of five residents and four relatives/whanau interviewed were complimentary of care received at the facility.D18.3 and 4: Dressing supplies are available and stored in a locked cupboard. Short term care plans are in place and reviewed monthly. Wound assessment and wound management plans are in place for one resident with a wound – a pressure ulcer. Two of two surgical wounds and one of one skin wound (skin breakdown from cellulitis) have no assessments wound management plan or evaluations that described the progress/ size of the wound completed. Improvement is required around documentation. The registered nurse and rest home coordinator described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. Pressure area in-service has been provided (June 2013).  |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Individualised care plans are completed by the registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Three monthly reviews occur or more often if required. All falls are reported on the resident accident/incident form. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. Pain monitoring, using a pain scale tool, is carried out for those on regular and prn pain relief including pre and post medication administration. There is a pain monitoring form. Wound assessment, management and evaluation forms are available. |
| **Finding:** |
| Three out of four wounds did not have an assessment, management plan or evaluation documentation completed. |
| **Corrective Action:** |
| Ensure wound care plans document a regular and on-going assessment, a management plan and progress/ evaluation of wound. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a diversional therapist at Marire rest home that is responsible for the planning and delivery of the activities programme.Activities are provided in the lounges, dining area and garden (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and the activities team (including the two activities coordinators from the sister site Maryann) meet each Monday morning to plan the week’s events. Residents receive a copy of the activity programme and it is also displayed on the notice boards and at reception. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. This is fed into the activities plan and this is reviewed six monthly as part of the care plan review/evaluation. The programme includes networking within the community with social clubs, churches and schools. . A record is kept of individual resident’s activities and progress notes completed. The resident/family/whanau as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.Marire rest home has its own van for transportation. There are plans for the upgrade of the vehicle.Residents interviewed stated that the exercise programme was fun and was adapted to meet individual resident needs. There is a Tai Chi chair exercise class for those that are less mobile. Five residents interviewed reported that they are informed of change to the programme. There is a Women’s group held monthly and a Men’s group. Minutes of residents/family meetings were sighted. These evidenced residents were able to make suggestions and that these were acted on. Residents interviewed stated that the activities programme had improved and they could take part as they wished.D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is at least a three monthly review by the medical practitioner. D16.4a: Care plans are reviewed and evaluated by the registered nurse six monthly or when changes to care occur as sighted in six of six care plans sampled. There are short term care plans to focus on acute and short-term issues. Four short term care plans reviewed evidence evaluation and are signed and dated by the registered nurse when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of short term care plans in use included; chest infection, falls and disturbing behaviour. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift. D16.3c: All initial nursing assessment/care plans were evaluated by the registered nurse within three weeks of admission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The registered nurse described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to community services team, dietitian, and mental health services for the older person.D16.4c: The service provided examples of where a resident’s condition had changed and the resident was reassessed for a higher level of care.D 20.1; Discussions with the registered nurse and rest home coordinator identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, occupational therapist and physiotherapist. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A discharge summary, transfer form, a copy of the resident medication chart and their resuscitation status accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family/whanau is made and this is documented. Family/whanau contact records document regular communication with family/whanau//EPOA regarding the transfer and updates on residents' condition. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medication policy covers all aspects of medicine management including prescribing, dispensing, administration, review, storage and disposal that align with accepted guidelines. There is one medication room. Medications are stored in a locked trolley in the medication room. The service uses four weekly blister packed medication management system. A medication checklist is completed on arrival by the registered nurse and rest home coordinator of the medication from the pharmacy and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are administered by caregivers who have completed a medication competency. Medication competency tests are completed annually and also if there is a medication administration error. Last held May 2013. There is a list of 'competent staff' in the front of the medication folders. There is a medication fridge and the temperature for the fridge is checked daily (sighted). Controlled drugs are stored in a coded safe in a locked storage cupboard in the medication room. Two medication competent persons sign for controlled drugs. Controlled drugs are audited weekly which includes a stock take, this was evidenced in the controlled drug register. Medication charts have photo ID’s. The service has an incident/accident form for the reporting of all adverse reactions and errors. Medication errors are reporting through the incident and accident reporting programme and corrective action plans initiated which are followed up. There is a signed agreement with the pharmacy. There is a medication return box and this is cleared by the pharmacy and signed out. Twelve out of 12 medication charts sampled show that all medications have been signed when administered according to the medication chart. The medication policy includes self-medication. There are currently five residents self-administering medications. An assessment to self-medicate was evidenced as completed and the registered nurse checks that medications have been taken as prescribed. GP reviews the medication charts three monthly and assesses residents' competence to continue to self-administer medications. There is emergency oxygen available. The regulators have been checked. Residents and family/whanau interviewed stated they are kept informed of any changes to medications. All eye drops sighted have been dated on the day they were opened. There is transcribing occurring on seven out of twelve medication charts. The rest home coordinator fills in the medication chart and the GP signs it. The lunchtime medication round was observed on day two of audit and correct medication administration procedures were not observed to be followed. It was noted that on the main medication round, the staff check the medications to be given against the administration chart and not the medication chart. Staff stated that all medications are checked on arrival so they are sure that the blister packs are correct. This is an area for improvement. Signing sheets correspond to instructions on the medication chart. Medication training last held May 2013.D16.5.e.i.2; Eleven of twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. One resident is a recent admission and therefore the three monthly review was not yet due. Medication management audits have occurred three monthly, last completed January 2014. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medication policies align with accepted guidelines. Medication reconciliation is completed by the registered nurse and clinical coordinator for new admissions and for all medications delivered by the pharmacy. All medication charts contain photographic ID, alert stickers for; a) controlled drugs, b) allergies and c) duplicate name and all medications prescribed are signed by the GP. Controlled drugs are kept in a coded safe in a locked cupboard. There is a weekly physical check. |
| **Finding:** |
| (i)In seven of twelve medication charts there was evidence of transcribing. (ii) When administering drugs the staff observed were checking the medication against the administration form and not the medication chart. |
| **Corrective Action:** |
| (i)Ensure that transcribing ceases. (ii) Ensure that when administering drugs staff giving medication should follow correct procedures and check medications against the medication chart prior to administration. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Marire rest home employs two cooks and all food is cooked on site. Both cooks have attained food safety standards 167 and have safe food handling certificates (sighted). There is a four weekly rotating winter and summer menu. A domestic services manager has been appointed.A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily. Hand hygiene education occurred as part of infection control education and a recent hand hygiene audit has been conducted. Environmental audits are conducted six monthly. Daily temperature checks of chiller, freezers, bain marie and dishwasher are maintained and documented. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff and in the communication book. Special diets being catered for include diabetic diets, and one resident on a gluten free diet. Weights are recorded monthly as directed by the registered nurse. There is an annual food service survey. All food in the pantry is rotated and stored off the floor. Opened food in the fridges and freezer is dated. The lunchtime meal was observed being served and was attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required. Five residents interviewed report satisfaction with food choices and state meals are well presented. The residents report that alternatives are offered if the dislike what is being offered and they are never made to feel like they are being difficult. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. Chemical training was held April 2013. There is a locked chemical cupboard in the kitchen.D19.2: Staff has been trained in safe food handling. |

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Marire rest home has employed a domestic services manager who oversees food services. There are two cooks and all food is cooked on site. Both cooks have attained food safety standards 167 and have safe food handling certificates (sighted). All kitchen staff has completed safe food handling training. A compulsory training/education schedule is in place for 2014 which covers topics such as (but not limited to) code of rights, elder protection, hand-washing, infection control, health and safety (fire safety, safe food handling) and cultural awareness. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. The manual includes (but is not limited to): food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities, hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety. The service has a large workable kitchen. All surfaces, the oven, the dishwasher are clean and cooking utensils and resident crockery and utensils stored appropriately. Cleaning is carried out as per the cleaning schedule, which is signed off when completed and checked by the domestic services manager. The pantry is a good size for food storage and all food is stored up off the floor with dry food containers sealed and labelled. Food supplies are rotated to the front when new supplies arrive. Opened food in the fridges and freezers are labelled and dated and unused food discarded after 24 hours. All fridges and freezer temperatures are recorded daily. Food temperatures are recorded daily. Dishwasher temperature is recorded daily. Documentation supports this. A first aid box is available and all chemicals are stored in a locked cupboard.  |
| **Finding:** |
| On admission residents have a nutritional profile, developed by the registered nurse, which identifies dietary requirements, likes and dislikes, food preferences including cultural preferences. This information is relayed to the kitchen. When there are any changes to resident’s dietary needs or physical abilities that may require the use of special equipment or a modification of diet these needs are communicated to the cook. Special diets are noted in the kitchen, which is able to be viewed only by kitchen staff. At present special diets being catered for include diabetic diets, and one resident on a gluten free diet. The resident on a gluten free diet confirms her needs are being met. The cook on interview was able to identify those requiring special diets and residents likes and dislikes. She states that there are always alternatives offered to residents who dislike the menu choice of the day. This was confirmed by residents interviewed. A special meal request for residents and family policy was added to the food services manual in January 2014. This was an initiative to provide for residents who have a sudden change in health status and to accommodate family who may be staying with them. It states that the cook needs 20 – 30 minutes to accommodate. The cook confirmed this was adequate notice. A size of meals survey was conducted in May 2013. This included likes and dislikes. This was collated and feedback was provided to the dietitian and the cooks. Changes to the menu and portion sizes were introduced following feedback from a residents meeting held on 20-May-13. Minutes of the meeting and a Quality Deficit Report detailing corrective action and sign off were sighted. An internal food handling audit was conducted in June 2013. Issues were identified and discussed at the risk management meeting. Recommendations made and signed off when completed. There is a summer and winter menu on a four weekly cycle which is designed and reviewed by a registered dietician on a two yearly basis. The service from this year has implemented an annual menu review. At the last review the dietitian recommended that there be more fruit at lunch and for the use of fortified milk. These recommendations have been implemented. The domestic service manager has implemented a project day for cooks every fortnight that allows for education, meetings and training. The last service day the dietitian gave a presentation on weight loss, purees and soft diets, vegetarian diets and the needs of those with dementia. Evaluation of the day was very positive.Residents have a choice of having breakfast in the dining room or having a tray delivered to their room. Midday meals and evening meals are served in the dining room unless a request for a tray is received. On day one of the audit both auditors witnessed the midday meal. The menu was advertised on a display board directly outside the dining room. The tables were laid nicely with the appropriate utensils and serviettes. The food was attractively presented on the plates. Salt and pepper were available on each table. Drinks were available. It was a homelike atmosphere with residents chatting amongst themselves or with the staff. Staff was courteous and unobtrusive and residents were not hurried. On interview with staff, residents and family/whanau all commented on how good the meals were. Positive comments on meals was evidenced in resident meeting minutes and included comments such as “good service” and “my suggestions have been followed up”.  |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals bottles sighted are labelled with the manufacturers labels. There is appropriate protective equipment and clothing for staff including gloves, shoe covers, gumboots, shoe covers and plastic aprons. There is a chemical spills kit handy. A hazard register identifies hazardous substance and staff interviewed indicated a clear understanding of processes and protocols. Chemical training was held April 2013. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards. MSDS sheets are available. |

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

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

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The layout of the facility meets all legislative requirements. The building holds a current warrant of fitness, which expires in 1 May 2014, and a current approved evacuation scheme. The service conducts a comprehensive system of checks including fire and sprinkler equipment, fire doors, emergency systems, emergency lighting, exits and fire hose reels using an external contractor. Last fire drill is recorded as occurring in December 2013. Electrical equipment is checked (February 2014). All doors and doorways in all wings of the facility require a repaint. There are large areas where the paint is peeling or where there are deep grooves and scratches. This is an area for improvement. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Corridors and rooms are all carpeted. The carpet was clean. The corridors have handrails. Corridors and rooms are large enough for mobility equipment to be used. Residents were observed moving freely around the areas with mobility aids where required. There are communal dining and lounge areas with smaller seating areas and a hairdresser’s room. There is adequate storage space. Reactive and preventative maintenance occurs. There is a part-time maintenance person who carries out daily requests for minor maintenance and keeps the maintenance manual updated. Water temperature temperatures are monitored monthly (sighted) with any variances reported immediately to the domestic services manager. Residents have plenty of personal space. External areas and gardens surrounding the facility are well maintained and attractive. Ramps to the outside areas provide safe access for residents and visitors. Pathways are maintained. There is an outdoor smoking area.The D15.3d: The lounge area is designed so that space and seating arrangements provide for individual and group activities. D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, and heel protectors and lifting aids. Interviews with three caregivers confirm this.  |

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

All buildings, plant, and equipment comply with legislation.

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The building has a current warrant of fitness. An external provider does a comprehensive system of checks including for fire and sprinkler equipment, fire doors, emergency systems, emergency lighting, exits and fire hose reels. All corridors and rooms are carpeted. Corridors have handrails. Reactive and preventative maintenance processes are in place. Water temperatures are monitored. Gardens and grounds are maintained. |
| **Finding:** |
| The doors and doorways in all wings have large areas where the paint is peeling or where there are deep grooves and scratches. |
| **Corrective Action:** |
| Ensure doors and doorways are repainted. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequate numbers of toilets and showers for each wing. There is safe flooring, seating and hand rails appropriately placed in the shower rooms. There are privacy locks on the doors. Vacant/in use signage is on the toilet/shower rooms. Residents interviewed confirmed their privacy was maintained when attending to personal hygiene cares.  |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are single rooms. Bedrooms in all the wings are of adequate size appropriate to the level of care provided. The bedrooms are personalised and spacious enough for residents to move safely around the room with the use of mobility aids. The rooms observed are personalised with the resident’s belongings. The staff report there is adequate space to carry out the resident cares and for the use of resident equipment as required. Residents interviewed (five) confirm their bedrooms are spacious and they can personalise them as desired. Four relatives/whanau interviewed state they are happy with their family members room. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is easy access to the communal areas. The lounge is open plan, comfortable with appropriate sating that is placed to allow for group and individual activities to occur. There is a second large lounge where residents can have visitors or spend time with quiet activities. There is also an alcove area adjacent to the office where small groups meet to sing together or just meet and talk. The dining room is open plan and is large and spacious. All the corridors are wide with appropriately placed handrails. Residents that require mobility aids have easy access to communal areas for relaxation, dining and activities. D15.3d: Seating and space is arranged to allow both individual and group activities to occur. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The domestic services manager coordinates the service. There are cleaning and laundry policies and processes. The cleaner’s trolley is well equipped and all chemical bottles are labelled. Protective wear including aprons, gloves and face shields are available in the sluice rooms and laundry. The laundry launders bed linen, towels and personal clothing. It also launders the linen from Maryann (sister site). There is a designated laundry worker. All linen bags are colour coded. The laundry has a clean/dirty flow. The laundry door is latched when not in attendance. Adequate linen supplies were sighted. Chemicals are stored in a locked room in the laundry. An external chemical supplier provides the chemicals, product wall charts, conducts quality control checks and provides training. Chemical training last April 2013. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Chemicals are stored safely in the laundry. Safety data sheets are readily accessible. Internal audits and resident meetings provide feedback on the service.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has implemented policies and procedures for emergencies. Fire drills are conducted six monthly and the last fire training occurred on 17 December 2013. The NZFS approved evacuation scheme is dated 28 September 2006. Marire has duel energy (gas/electric) sources for heating and hot water. Battery operated emergency lighting is in place. There is gas BBQ for cooking and extra blankets for heating. Call bells are in use. Security procedures are established. Staff wear uniforms and name badges. The building is secured during the hours of darkness and all visitors and contractors to the facility need to ‘sign in’ for identification. There is water storage for at least three days. There is a supply of equipment and food for at least three days. There is also an agreement in place with a local supplier for additional food supply. Residents individual plans identify additional needs as required. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate natural light in all communal rooms. Bedrooms have at least one window to allow natural lighting and opens safely to allow for ventilation. There are water filled radiators in the bedrooms and night store heaters in the corridors and communal areas. The temperature can be adjusted to suit individual resident temperature preference. Five residents and four family/whanau interviewed stated the temperature of the facility was comfortable.  |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Marire does not have any residents on restraint. Policies and protocols are congruent with NZS 8134.0. The use of enablers is clearly described in the policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. For example, a lap belt in a wheelchair to maintain positioning for self-propulsion. Interview with the restraint coordinator (RN), three caregivers and review of documents confirmed that there is no resident using restraint on both days of the audit. There is one resident using a bed rails as an enabler and the resident signed the consent form for use of this. All required documentation for enabler use is recorded in the restraint folder and resident’s file. Staff receive training around restraint minimisation and enablers and staff interview confirm their knowledge around this.  |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Marire has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There is an infection control policy and procedure manual which is readily accessible to all staff. The nurse manager undertakes the role of infection control and prevention. Infection control is a standing agenda item at the three monthly risk management meeting where all issues and infections are discussed with staff. All results and infection control matters are reported to the nurse manager on a monthly basis or sooner if there is an issue. She collates a monthly record of infections data and then a copy of these results are retained at the staff reading folder for staff to read and sign off. The RN, the nurse manager and the resident's general practitioner are notified promptly of any positive pathology that is identified as an infection. Discussion with three caregivers confirmed that the nurse manager is always available for emergent issues. Infection control programme is reviewed annually and most recently, the service purchased Bug Control Infection Prevention and Control Manual. Staff are well informed about infection control practices and reporting. Memo’s related to infection control issues are noted in the staff reading folder. The infection control coordinator’s job description describes the key responsibilities and performance indicators of the Infection control activities. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection control coordinator is the nurse manager who most recently undertook this role. She is supported by the RN and the infection control coordinator from Maryann home and hospital. The infection control coordinator stated that she also has good external support from the infection control advisors from the local DHB and resident’s GPs. All staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme. There are adequate resources to implement the infection control programme. Infection control policies and procedures are used to minimise the risk of exposing residents and staff to others with infection risk. Staff are advised about prevention of transmission of disease and, if sick, to remain at home. Visitors are informed of any outbreak issues and advised not to visit if unwell.  |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. The infection control policies and procedures are reviewed in 2013 and these are current and comply with standards, legislation and guidelines for infection control practises. The service also purchased Bug Control Infection Prevention and Control Manual 2014. All staff are involved in the implementation of policies.  |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control co-ordinator is responsible for co-ordinating education and training of staff. Orientation package includes specific training around hand washing and standard precautions. Training on infection control is an agenda item at caregiver forums, food service and housekeeping meetings. Staff have an individual hand washing audit annually. Food services and housekeeping staff receive infection control education relevant to their areas. Infection control is included in the annual in-service training programme. Infection control education is last provided on February 2014 together with staff from Maryann home and hospital. Information is provided to residents and visitors which is appropriate to their needs. This is documented in medical records. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The type of surveillance undertaken is appropriate to the size and complexity of the service. Mc Geer (2012) definition is used for the identification and classification of infection events, indicators or outcomes. Surveillance data is collected and results of surveillance are acted upon, evaluated, and reported to relevant staff in a timely manner. Classification of infection events are included in the infection report form. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the three monthly risk management meetings, and caregiver’s forum. Each resident has an individual infection report that includes reporting on skin, eye, urinary, respiratory, and gastrointestinal and other infections that may be identified. The Infection control coordinator reports no infectious outbreaks since the previous audit. Individual infection report forms are completed for all infections and is kept in the resident files. Surveillance reports includes comments around if the infection is resolved, risk factors, invasive devices and the appropriate referrals.  |

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

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

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

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

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

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