

Lonsdale 2005 Limited

Current Status: 3 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

Lonsdale Total Care Centre is a 50-bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit is 39 residents.

Riverside lodge is a 20-bed rest home. The total number of residents at Riverside on the day of audit is 14 residents.

The two facilities are managed by an experienced RN/facility manager who has been in the role for two years. She is supported by a care manager appointed seven months ago who provides clinical management and leadership across the two facilities. Non-clinical services are managed by the household manager and an office manager. Governance is provided by the acting chief executive officer (CEO) who is one of the two business owners.

The residents and family/whanau interviewed are complimentary about the service delivery and care received at both facilities.

There are improvements required around pain management, documentation of interventions and GP medication reviews.

Audit Summary as at 3 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 3 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.		Standards applicable to this service fully attained.
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Organisational Management as at 3 March 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 3 March 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 3 March 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 3 March 2014

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

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 3 March 2014

Consumer Rights

Lonsdale total care and Riverside rest home practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the Code are displayed in the care centres.

There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process.

There are implemented policies to protect residents from discrimination or harassment. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau.

Organisational Management

The organisation has an annual business and quality plan in place with annual quality objectives. Quality, health and safety and infection control are set agenda items at management and staff meetings. The service is actively involved in on-going quality projects to improve outcomes and service delivery for the residents.

Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal audits and receive meeting minutes. The service has comprehensive policies/procedures to provide rest home, hospital and dementia level of care. All staff have completed an orientation programme. There are documented job descriptions for all positions, which detail each position's responsibilities, accountabilities and authorities.

There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. There is a 2014 education planner in place that includes compulsory training for aged care staff.

Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are evaluated six monthly. The resident/family/whanau confirm they are involved in the care plan process and review. Short-term care plans are in use for changes in health status. There are improvements required around pain assessments, wound care documentation, documentation of diabetes management and documentation of restraints risk and comfort during restraint periods. Short-term care plans are in use for changes in health status.

The diversional therapist provides an activities programme for the residents that is varied, interesting and involves the families and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There is an improvement required around three monthly GP medication reviews.

Meals are prepared on site at both Lonsdale and Riverside facilities. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and Appropriate Environment

Both the Lonsdale Total Care building and Riverside Lodge hold a current warrant of fitness. Fire equipment checks are conducted by an external fire safety contractor. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using the mobility aids or wheeled chairs. The hallways are wide and have hand rails appropriately placed. There is a continued plan implemented for staged deliveries of new furniture and seating. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme for both facilities. There are six monthly fire drills. Staff have attended emergency and disaster management, there is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

Restraint Minimisation and Safe Practice

There are comprehensive policies and procedures that meet the restraint standards. There are two restraints co-ordinators with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. Internal audits against compliance of restraint policy and standards are completed; there are six residents with restraints in use.

Infection Prevention and Control

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. The Infection Control team is part of the combined quality meeting. Reports and surveillance data are discussed at staff meetings. All staff received infection control education on orientation and attend education as offered. Hand hygiene competencies are completed.

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:	Lonsdale and Riverside Lodge 2005 Limited
Certificate name:	Lonsdale and Riverside Lodge 2005 Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Lonsdale Total Care Centre; Riverside Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 3 March 2014 End date: 4 March 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	53

Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	10
Other Auditors	XXXXX	Total hours on site	14	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	28	Total audit hours off site	20	Total audit hours	48
Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	68	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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 Wednesday, 9 April 2014

Executive Summary of Audit

General Overview

Lonsdale total care is a 50-bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit is 39 residents (six of 12 rest home residents, 25 of 26 hospital residents and eight residents in the 12-bed dementia unit). Riverside lodge is a 20-bed rest home. The total number of residents at Riverside on the day of audit is 14 residents including one respite resident.

Governance is provided by the acting chief executive officer (CEO) who is one of the two business owners.

The two facilities are managed by an experienced RN/facility manager who has been in the role for two years. She is supported by a care manager appointed seven months ago who provides clinical management and leadership across the two facilities. Non-clinical services are managed by the household manager and an office manager.

The residents and family/whanau interviewed are complimentary about the service delivery and care received at both facilities.

There are improvements required around pain management, documentation of interventions and GP medication reviews.

Outcome 1.1: Consumer Rights

Lonsdale total care and Riverside rest home practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed in the care centres.

There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process.

There are implemented policies to protect residents from discrimination or harassment. There is an open disclosure policy that staff understand.

Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau.

Outcome 1.2: Organisational Management

The organisation has an annual business and quality plan in place with annual quality objectives. Quality, health and safety and infection control are set agenda items at management and staff meetings. The service is actively involved in on-going quality projects to improve outcomes and service delivery for the residents.

Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal audits and receive meeting minutes. The service has comprehensive policies/procedures to provide rest home, hospital and dementia level of care. All staff have completed an orientation programme. There are documented job descriptions for all positions, which detail each position's responsibilities, accountabilities and authorities.

There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. There is a 2014 education planner

in place that includes compulsory training for aged care staff.

Outcome 1.3: Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are evaluated six monthly. The resident/family/whanau confirm they are involved in the care plan process and review. Short-term care plans are in use for changes in health status. There are improvements required around pain assessments, wound care documentation, documentation of diabetes management and documentation of restraints risk and comfort during restraint periods. Short-term care plans are in use for changes in health status.

The diversional therapist provides an activities programme for the residents that is varied, interesting and involves the families and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staffs responsible for medication administration have completed annual competencies and education. There is an improvement required around three monthly GP medication reviews

Meals are prepared on site at both Lonsdale and Riverside facilities. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Outcome 1.4: Safe and Appropriate Environment

The Lonsdale total care building holds a current warrant of fitness, which expires on 31 March 2014. The Riverside lodge building warrant of fitness expires 26 November 2014. Fire equipment checks are conducted by an external fire safety contractor. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. The hallways are wide and have hand rails appropriately placed. There is a continued plan implemented for staged deliveries of new furniture and seating. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme for both facilities. There are six monthly fire drills. Staff have attended emergency and disaster management, there is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

Outcome 2: Restraint Minimisation and Safe Practice

There are comprehensive policies and procedures that meet the restraint standards. There are two restraints co-ordinators with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. Internal audits against compliance of restraint policy and standards are completed; there are six residents with restraints in use.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. The Infection Control team is part of the combined quality meeting. Reports and surveillance data are discussed at staff meetings. All staff received infection control education on orientation and attend education as offered. Hand hygiene

competencies are completed. There is a requirement for Public Health to be notified in the event of an outbreak

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	0	1	1	0	0
Criteria	0	99	0	1	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	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
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 Moderate	1) Four of five skin tears and one of one-pressure area wound care plans did not evidence frequency of dressing changes. 2) There are no formal pain assessments for two rest home residents on regular and prn pain relief and one hospital resident on regular assessment controlled drugs. 3) There are no	1) Ensure all wound care plans reflect the frequency of dressing change. 2) Ensure that pain assessments are completed for all residents who are on regular and prn pain management medication. 3) Ensure that all residents with diabetes have documented instructions for the management and monitoring of diabetes. 4) Ensure risks identified with restraint use	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				documented instructions for management of diabetes or blood sugar monitoring for two residents who have diabetes (one on insulin). 4) Restraint risks identified via the assessment process are not all included in the care plan; 5) Three unwitnessed falls with head injury evidenced only one set of neurological observations at the time of injury.	and comfort cares to be carried out during the restraint period are documented in the care plan. 5) Ensure neurological observations post falls with head injury are completed as per best practice for the monitoring of head injuries. The care manager issued a memo to all RNs on the day of audit regarding the frequency of neurological observations.	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Four out of eighteen medication charts have not been signed after a three monthly review by the GP.	Ensure the GP signs the medication chart after completing the 3 monthly medication review.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: The service has available information on the Code of Health and Disability Services Consumers' Rights. Advocacy pamphlets and the code of rights are clearly displayed in the hospital wing entrance and dementia unit at Lonsdale and the main entrance at Riverside. Six residents (two hospital and four rest home) and seven relatives (two dementia and five hospital) interviewed confirmed that information has been provided around the code of rights. There is a resident rights policy in place. Code of Rights training was completed in February 2013 and February 2014. Discussion with five caregivers and three registered nurses identified all are aware of the Code of Rights and could describe the key principles.

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

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

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

There is a welcome information pack that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their advocate, enduring power of attorney or legal representative. The facility manager is the privacy officer and has completed customer services training. The facility manager and care manager are available to discuss concerns or complaints with residents and families at any time. Residents and family members interviewed state they received sufficient verbal and written information to be able to make informed choices on matters that affect them. D6.2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, complaints policy, code of rights, H&D Commission and advocacy pamphlet. Advocacy brochures are displayed and readily available.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The facility provides physical and personal privacy for residents. There are single bedrooms and shared bedrooms within the rest home, hospital and dementia unit. All bedrooms at Riverside lodge are single. Privacy curtains are in place. Residents/families consent to the sharing of rooms. During the audit, staff are observed treating residents with respect and ensuring their dignity is maintained. Staff are observed knocking on the resident's door and waiting to be asked to enter the room. Staff interviewed are able to describe how they maintain resident privacy.</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Residents are encouraged to personalise their bedrooms. Residents interviewed stated staff are respectful of their belongings.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality care within a home environment. Residents and relatives interviewed state they are involved in decisions about their care and the staff are caring, respectful and residents are treated as individuals.</p> <p>The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with five caregivers (across the three levels of care) described providing choice during daily cares including shower times, settling times and choice of clothes to wear.</p> <p>There is an abuse and neglect policy that is implemented. Abuse and neglect training is included as part of the staff orientation programme and on-going. Discussions with residents and family members are positive about the care provided.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>A3.2 There is a Maori care and cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a comprehensive guide that acknowledges the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori including death and dying. The policy includes references to other Maori providers available and interpreter services. The service has a longstanding relationship with Maori in the community and are guided by their wishes and preferences when caring for Maori. The resident's rights and responsibilities is written in Maori. The service have three residents who identify as Maori. A Maori assessment plan completed on admission, which is specific to their cultural wishes including whanau involvement. The service has access to local Kaumatua (Maori wellbeing advisor) for the Maori residents.</p> <p>D20.1i The service has established a link with iwi through a local Maori in the community. Staff attended Treaty and cultural training provided by the Maori wellbeing advisor in February and June 2013. The Maori care and cultural safety policy identifies the importance of whānau. Interviews with five caregivers confirmed knowledge of Maori care guidelines for cultural safety and could describe the importance of including family in the delivery care to Maori residents.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Lonsdale and Riverside has policies and procedures to guide staff practice to meet the individual ethnic, cultural, spiritual values and beliefs. Individual culture, values and beliefs information is gathered on admission with resident/family involvement and is integrated into residents' care plans and activity plans. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services, spiritual visitors and attending their own church and other community groups as desired. Care plans and activity plans include cultural and spiritual beliefs and are reviewed six monthly to assess if the resident spiritual, cultural, values and beliefs are being met.</p> <p>D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process.</p> <p>D4.1c: Care plans reviewed included the resident's spiritual, cultural, values and beliefs social and recreational needs.</p>

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

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Job descriptions and duties lists include responsibility of the position. All employees sign a copy of the code of rights, which is sighted on eight personnel files sampled. The Code of Conduct and residents rights and responsibilities are included in the orientation pack an on-going. There are policies in place to guide staff practice. Staff are observed to be professional within the culture of a family environment. The registered nurses works within professional boundaries as defined by Nursing Council. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with 12 staff (four registered nurses, five caregivers, cook, DT and maintenance person) and the facility manager and care manager could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The owners (two) and management team are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided.

The service has implemented policies and procedures that are developed and reviewed by key people within the organisation. The policies and procedures meet legislative requirements. Caregivers interviewed state there are caregiver guidelines and care plans in place to guide the delivery of care to residents. They receive a verbal handover from the RN and there is a daily handover sheet for every shift that details significant events. A communication book is used to ensure staff are kept informed on daily matters.

There is a comprehensive orientation programme in place and staff complete competencies relevant to their role. The care manager has completed InterRAI training RN's scheduled to attend InterRAI training this year. There are clinical audits completed. Issues are identified and corrected as they arise.

A2.2 Services are provided that adhere to the health & disability services standards. There is an implemented quality improvement programme.

17.7c There are implemented competencies for the registered nurses and caregivers. 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The management promote an “open door” policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Information is provided in formats suitable for the consumer and their family. There are residents meeting held regularly at both sites with opportunity for feedback on the services. Residents receive regular newsletters that keep them informed on all matters that affect them, community news and facility renovations etc. Annual relative and resident surveys are completed (August 2013) that provide feedback on all areas of the service. Open disclosure is practiced. Twelve of 12 accident/incident forms sampled evidenced the family had been notified of the incident/accident. Family/whanau contact forms in resident files evidence discussions and notification of resident changes to health. Staff have attended code of rights education. On-line training has recently been purchased for open disclosure. There is improved consistency of medical care with GPs from the local primary health organisation regularly attending the residents. The relative survey result included positive comments regarding improved GP service.

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. Relatives and residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss information and the admission agreement with management.
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 Seven relatives (two dementia and five hospital) interviewed stated that they are always informed when their family member’s health status changes.
D11.3 The information pack is available in large print and advised that this can be read to residents. The code of rights is in Maori. Interpreter services are available as required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Informed consent forms are also written in Maori. Consent is obtained for release of health information, photograph for identification and display, transport, on-going cares and care choice and release of information to family or representative. Five caregivers interviewed are familiar with the code of rights and informed consent when delivering resident cares.</p> <p>Advance directives for competent residents are appropriately signed. Where the GP has deemed the resident incompetent to make a decision there is no advance directive for resuscitation. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Advance directives are reviewed by the GP and residents are informed of their choice to withdraw or change their advance directive status.</p> <p>D3.1.d: Discussion with two family members identifies that the service actively involves them in decisions that affect their relative's lives. Advanced directives are completed for residents who are competent to make the decision.</p> <p>D13.1: There were eight signed admission agreements.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed in the entrance to the hospital wing and dementia unit and at Lonsdale and at Riverside lodge front entrance. Caregivers interviewed are aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with five residents confirmed that they are aware of their right to access advocacy. D4.1d; Discussion with seven family identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e, The resident files includes information on resident's family/whanau and chosen social networks.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a policy to maintain links with family and community and this is identified with the resident on initial assessment and development of the activity care plan. Residents are supported to attend community activities and functions as appropriate. The service maintains key linkages with other community organisations including senior citizens, RSA, churches and schools. Residents are invited to community functions and events. Speakers (health and disability advocate) and entertainers to visit the facility. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Families interviewed state they are always made to feel most welcome when they visit.

D3.1h; Discussion with seven relatives confirm that they are encouraged to be involved with the service and care

D3.1.e. Discussion with staff and relatives state residents are supported and encouraged to remain involved in the community and external groups such as churches and concerts.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The facility manager is the privacy officer for the organisation. The care manager is involved in clinical investigations as necessary. There is a current complaints register. There is evidence of verbal concerns (four) and written concerns (five) addressed following the complaints procedure in 2013. There has been one written complaint and one written concern in January 2014. Both have been resolved to the satisfaction of the complainant. The health and disability advocate has been involved in the written complaint. Where appropriate surveys or internal auditing is completed as part of the monitoring process. Compliments/concerns/complaints brochure/forms are readily available. There is a compliments and concerns/complaints box at the front entrance. Staff interviewed are knowledgeable in the complaints and concerns process.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry. Outcomes of the concerns/complaints are discussed at the CEO/management meetings and staff meetings as appropriate. Discussion with six residents and seven relatives confirmed they were provided with information on complaints and complaints forms and are comfortable approaching management with any concerns/complaints</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: Lonsdale total care is a 50 bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit is 39 residents (six of 12 rest

home residents, 25 of 26 hospital residents and eight residents in the 12 bed dementia unit). The service has no residents under the medical component of their certification. Riverside lodge is a 20 bed rest home. The total number of residents at Riverside on the day of audit is 14 residents including one respite resident. There are two business owners of the two facilities. Governance is provided by the acting chief executive officer (CEO), one of the business owners. The two facilities are managed by an RN/facility manager who has been in the role for two years. The facility manager has completed post registration studies in health studies in the UK and master of nursing in N.Z. She has 10 years of aged care experience including the role of healthy community development nurse for the local community. A care manager was appointed seven months ago to support the facility manager and provide clinical leadership across the two facilities. The care manager worked in education and business prior to becoming a registered nurse. He has five years' experience working at the DHB in an over 65 year's surgical ward. Non-clinical services are managed by the household manager and an office manager. The CEO meets monthly with the facility manager, care manager, household manager and administration manager. The CEO develops the business and quality plan in consultation with the management team. The 2013 business/quality plan has been reviewed with achievement including (but not limited to) environmental improvements, improved GP service, clinical continence survey and a product review and refurbishment. The 2014 business/quality plan has been developed and will be signed off by the CEO at the next meeting. The facility manager submits the capital expenditure plan for approval. The capex plan includes an upgrade for the call bell system and on-going refurbishment (ultra-low beds and specialised hospital lounge chairs. CEO/management meeting minutes sighted evidenced regular reviews of the 2013 business/quality plan. The business/quality plan clearly identifies the purpose, scope, values and direction of the organisation. The governance, management and staff are committed to the organisations mission statement "To provide a quality, homely environment in which our residents may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed". The service has increased occupancy over the last year.

E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

ARC,D17.3di : The facility manager has maintained at least eight hours of professional development annually including palliative care modules, attending relevant courses and forum provided at the DHB.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The care manager is the acting manager during the temporary absence of the facility manager. D19.1a; a review of the documentation, policies and procedures and from discussion with six staff identified that the service operational management strategies, quality programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are organisational policies to guide the facility to implement the quality management programme including (but not limited to); quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. Quality assurance, quality improvements, health and safety, hazards, infection control, internal audit outcomes, trends and corrective actions are all discussed at all service meetings. Minutes sighted evidence there is discussion around concerns, compliments, health and safety, infection control, audit and survey results and corrective actions and improvements. Staff interviewed state they are well informed and receive quality and risk management information such as accident incident stats and infection control stats. The CEO/management meetings are held monthly. Reports are provided from the health and safety representatives and infection control co-ordinators to the CEO/management meeting.

A staff survey July 2013 identified an improvement required around the sharing of information. Quality initiatives introduced with the appointment of the care manager have been RN's providing a weekly report to the care manager. The care manager completes a daily report for the facility manager. An advisory care team group has been commenced who are involved in operational concerns. The five caregivers and three registered nurses interviewed speak highly of the management team and state they are involved in the operational goals of the organisation and are asked for suggestions and feedback on quality initiatives. Staff receive a monthly "Team Talk" newsletter.

Clinical guidelines are in place to assist care staff with such issues as incontinence, challenging behaviour, falls prevention, nutrition and hydration, skin care and wound management and pain management. Internal audits are completed for (but not limited to); clinical documentation, hygiene and grooming, challenging behaviour, medication, food services, hand washing, cleaning service.

A clinical quality initiative project was conducted in consultation with the education centre competency assessment programme students. The project was to research and identify at risk residents using the body mass index (BMI) measurements. All residents had their BMI taken and documented. The residents identified with a BMI below 18 and at risk of weight loss were several residents within the dementia unit who constantly walked/paced around the facility and had poor concentration and focus at meal times. Individual resident programmes of diversional activities and distraction techniques are in place to help break the walking cycle of these residents in order to conserve energy. Nutritious snacks and finger foods are readily available and care staff encouraged the residents to sit and eat small snacks often. They would be encouraged to have fluids and make cups of tea with the care team. There would be social gatherings at morning tea under supervision in the rest home dining room as the residents appeared to enjoy the social interaction and focused on eating the morning tea when in a group. Ice lolly and jelly rounds were implemented daily. The programme has been successful in preventing weight loss in dementia residents.

Surveys completed are; residents (August 2013), food survey (February 2013) and staff survey (July 2013). The survey results are collated surveys to identify if there any areas for improvement.

D5.4 The service has the appropriate policies and procedures to support service delivery. The service's policies are developed and reviewed by the managers of each service.

D19.3: There is a Quality and Risk management programme in place that includes health and safety and hazard identification. Staff report any hazards identified on the daily maintenance request/hazard form. The hazard register is reviewed annually last in January 2014. Each service has specific hazards and controls identified to their area. An example of a recent hazard identified is a crack in the dementia unit chimney after the earthquake in January 2014. The chimney was checked immediately by a contractor. The area was isolated and the chimney removed. The hazard and corrective action was linked into the health and safety minutes, management meeting minutes and staff minutes. The CEO was informed and the insurance company notified.

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. Prevention strategies and corrective actions is documented in the residents care plan.

There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff (on orientation and civil defence training (January 2013), monthly fire testing, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. Organisational risks are categorised as environmental and equipment, resident safety, financial risk, confidentiality, staff, food services and legal liability. There is evidence of monthly collation, analysis and monitoring of infection control, restraint use, accidents/incidents and audit outcomes. Staff interviewed state they are kept informed, receive information and discuss risk management and hazard identification at the staff meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

As part of risk management plan there is an accident/incident policy, which includes reference to open disclosure, level of seriousness and the responsibility for investigation, cause and contributing factors, corrective actions and quality improvements. Monthly data collection of accident/incidents are completed by the 20th of each month and includes (but not limited to): falls, skin tears, bruise/haematoma, medication, behavioural incidents and near misses.

When an incident occurs the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. The RN on duty completes a clinical assessment and identifies preventative and corrective actions. There is an improvement required around the monitoring of neurological observations (link 1.3.6.1). All incidents/accidents are signed off by the care manager who conducts a further investigation if required. The care staff (interviewed) state they are informed of any falls and significant events at shift handovers and receive information and data at staff meetings. There is evidence of open disclosure for 12 of 12 incident/accident forms sampled. Family interviewed state they are always contacted if there have been any incidents.

There is evidence of monthly falls management and prevention. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. There is evidence of physiotherapist referrals and involvement in resident assessments. Corrective actions and monitoring requirements are linked to the long term care plan.

Monthly data is taken to the management meeting and staff meetings. The five caregivers interviewed could describe the process for reporting of incidents and accidents. D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action.

D19.3c The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There are human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (one facility manager, one care manager, three care staff, one diversional therapist, one cleaner, one kitchen hand). The recruitment and staff selection process requires that police vetting and reference checks are completed prior to employment to validate the individual's qualifications, experience and suitability for the role. Registered nursing staff have current

practicing certificates. All files evidence a signed job description.

There is a comprehensive orientation programme that includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role.

There is a documented in-service programme for education that covers compulsory requirements including standard precautions, safe manual handling, medication administration, and cultural awareness training, and advocacy, code of rights, civil defence, falls prevention and pain management. Other clinical in service is provided. A recent initiative to improve staff attendance at compulsory education and staff meetings has been the implementation of an eight hour training day that includes a staff meeting and mandatory training. The first training day had 13 attendees. Another 10 days will be scheduled this year to allow all staff to attend. Nine care staff completed the Hospice modules in 2013. Evaluations received identify an increase in knowledge around palliative care in particular to grief and loss. The course has given care staff a greater understanding of palliative care, which has improved the service delivery around terminal illness. Further courses are scheduled for 2014 to allow all care staff to attend.

Competencies are identified and completed. Staff responsible for medication administration complete annual competencies and attend annual education sessions. RNs, enrolled nurses and care staff are encouraged and supported to undertake external education. Six of eight staff files sampled had annual appraisals. Two staff are not due for an appraisal.

D17.8 Eight hours of staff development or in-service education has been provided annually.

E4.5f Caregivers employed in the dementia unit have completed the required dementia standards.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Staffing rosters were sighted and there are an adequate number of staff on duty to meet the resident’s needs on different shifts. The Lonsdale staffing in the rest home/hospital is as follows; two RNs on morning duty; one RN on afternoon and night shift, four care staff on morning shift, three care staff on afternoon and one on night shift. There are two care staff on duty in the dementia unit on morning and afternoon shift with one care staff member on night shift. Riverside has an RN on duty Monday to Friday and a care staff member on duty for the morning, afternoon and night shift. The facility manager is a RN and works fulltime. The care manager covers both facilities and works fulltime. The morning duty RN at Lonsdale is the on call RN. Staff at Riverside access the RN at Lonsdale after hours for advice and the on call RN if a clinical assessment is required.</p> <p>There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Six residents (two hospital and four rest home) interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly.</p>

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record.
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 a secure office in all areas.
Care plans and notes are legible and signed and dated by the RN. Individual resident files demonstrate service integration with allied health notes and medical notes.
D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.
Policies contain service name.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Prior to entry, all potential residents have a needs assessment, completed by the needs assessment and 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 residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. Six residents and seven family/whanau confirm they had received all relevant information prior to or on admission.</p> <p>E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. <p>D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D14.1 Exclusions from the service are included in the admission agreement.</p> <p>D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E3.1 Two files were reviewed and all include a needs assessment as requiring specialist dementia care.</p>

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

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

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence: The admission policy describes the declined entry to services process. Lonsdale and Riverside records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy and process that describe resident's admission and assessment procedures.

D16.2, 3, 4 A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term care plan is developed in the eight of eight resident files sampled (three hospital, one rest home, two dementia at Lonsdale and two Riverside rest home). In eight of eight resident files sampled the initial admission assessment and initial care plan summary were completed and signed off by a registered nurse. The resident assessment is carried out on admission and reviewed six monthly or earlier if resident health status changes. These are completed by the registered nurse (RN) with input from caregivers, the activities co-ordinators, family/whanau and any other relevant person.

There is evidence of resident and/or family/whanau/EPOA involvement in the care planning process. Activity assessments and the activities care plans have been completed by the diversional therapist.

A range of assessment tools completed on admission are evident in the eight resident files sampled and completed at least six monthly including (but not limited to); a) nutritional and dietary assessments, b) pressure area risk assessment, c) continence assessment d) coombes falls risk assessment e) wound assessment and g) disturbing behaviour assessment.

Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs.

There is a verbal and written handover for caregivers and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Five caregivers and three registered nurses could describe a verbal handover at the start of each duty that maintains a continuity of service delivery. All eight files identified integration of allied health including oncology, physiotherapist, palliative care, health care practitioner, speech language therapist, eye clinic, dermatology, rheumatologist and podiatrist.

Medical assessments are completed within 48 hours of admission by the GP in eight of eight resident files sampled. The GP (interviewed) practices at the local health care that is owned by the PHO. Two GPs provide medical services to the residents at Lonsdale and Riverside. There are twice weekly visits that includes three monthly reviews and visiting residents of concern. The GP states there has been an improvement in consistency of medical care and communication between the RN team and the GP practice. Requests for visits are appropriate and timely. The PHO is part of the palliative care partnership model. After hours, GP advice can be sought from the practice between 5.30pm and 8pm. From 8pm weekdays and the weekends medical cover is provided by the regions emergency department.

Tracer Methodology:

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

Tracer Methodology: hospital resident

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

Tracer Methodology: Rest home resident

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. 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.</p> <p>All resident files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission. Relatives and residents advised on interview that assessments were completed in the privacy of their single room.</p> <p>A range of assessment tools is completed on admission if applicable including (but not limited to); a) resident food preference b) falls risk (and LITE resident profile) d) Braden pressure area risk assessment, e) continence and bowel, f) wound assessment g) restraint assessment and i) behaviour assessment (as applicable). Pain scale and pain monitoring chart is available but there is no evidence of a pain assessment (link 1.3.6.1).</p> <p>In eight files sampled there were no pain assessment for three residents who identify pain as an issue. One hospital resident at Lonsdale with pain identified on the long term care plan did not have a pain assessment in place. There is a disturbing behaviour assessment and monitoring form. The behaviour chart describes the incident, behaviour and consequences.</p> <p>E4.2; Two dementia resident files reviewed included an individual assessment that included identifying diversionary, motivation and recreational requirements.</p> <p>E4.2a: Challenging behaviour assessments are completed where required, as a result de-escalation strategies have been included in the long term care plan.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Service delivery care plans overall demonstrate service integration and are individualised (however, link improvements 1.3.6.1). Assessments and care plans include input from allied health such as physiotherapist, podiatrist, dietitian and specialist services as required. There is evidence of a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. Care plans cover key areas such as (but not limited to) falls management, nutrition, pressure area prevention and continence management. D16.3k: Short term care plans were in place with interventions, management and evaluations. All are signed off when resolved. D16.3f: All eight of eight resident files reviewed identified that family were involved. Seven 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.

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

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

Attainment and Risk: FA
Evidence:

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>The service provides services for residents requiring rest home, hospital and dementia level of care at Lonsdale total care and rest home level of care at Riverside lodge. Individualised care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation.</p> <p>The five caregivers and three registered nurses interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, gloves, aprons and masks.</p> <p>Wound assessment plans include causative factors that may delay healing, type of wound, allergies, treatments and dressing frequency, interventions and evaluations. Body maps show the location of the wound. Caregivers are competency assessed for basic wound care and dressings. The RN's review wounds and record progress. Four of five skin tears and one of one pressure area did not evidence frequency of dressing change. This is an area requiring improvement. Wound care advice is readily</p>

available to the RN's.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Catheter management plans are used (as sighted) for residents with indwelling catheters. Specialist continence advice is available as needed and the RN on duty could describe the referral process. There are adequate supplies of continent products in all areas.

All falls are reported on the resident accident/incident form. Three unwitnessed falls with head injury evidenced only one set of neurological observations at the time of injury.

Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. There is evidence of physiotherapist referrals and involvement in resident assessments.

Palliative care support is available through the hospice nurses, specialists, and community district nurses. RN's and caregivers have attended a palliative care education course and have completed stage 3.

Residents' weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated.

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 no formal pain assessment completed for two rest home residents and one hospital resident who identify pain and are on regular and prn pain relief.

Documentation of interventions is required in the long-term care plan for two residents with diabetes (one on insulin). Restraints assessments are completed identifying risks associated with restraint use. The resident (if applicable), RN, restraints co-ordinator and GP are involved in the restraint assessment, which identifies the risks of restraint use. There is a requirement to document in the care plan the risks identified with restraint use and comfort cares to be carried out during the restraint period.

D18.3 and 4; Dressing supplies are available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

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

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

Attainment and Risk: PA Moderate

Evidence:

The service provides care for residents requiring rest home, hospital and dementia level of care at Lonsdale total care and rest home level of care at Riverside lodge. Individualised care plans are completed by registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Wound assessment plans include causative factors that may delay healing, type of wound, allergies, treatments and dressing frequency, interventions and evaluations. Body maps show the location of the wound. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. A pain monitoring form using a pain scale tool is carried out for those on regular and prn pain relief including pre and post medication administration. The resident (if applicable), RN, restraints co-ordinator and GP are involved in the restraint assessment, which identifies the risks of restraint use. 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.

Finding:

1) Four of five skin tears and one of one-pressure area wound care plans did not evidence frequency of dressing changes. 2) There are no formal pain assessments for two rest home residents on regular and prn pain relief and one hospital resident on regular assessment controlled drugs. 3) There are no documented instructions for management of diabetes or blood sugar monitoring for two residents who have diabetes (one on insulin). 4) Restraint risks identified via the assessment process are not all included in the care plan; 5) Three unwitnessed falls with head injury evidenced only one set of neurological observations at the time of injury.

Corrective Action:

1) Ensure all wound care plans reflect the frequency of dressing change. 2) Ensure that pain assessments are completed for all residents who are on regular and prn pain management medication. 3) Ensure that all residents with diabetes have documented instructions for the management and monitoring of diabetes. 4) Ensure risks identified with restraint use and comfort cares to be carried out during the restraint period are documented in the care plan. 5) Ensure neurological observations post falls with head injury are completed as per best practice for the monitoring of head injuries. The care manager issued a memo to all RNs on the day of audit regarding the frequency of neurological observations.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA**Evidence:**

There is one diversional therapist (DT) employed 30-36 hours Monday to Friday to cover Lonsdale total care and Riverside lodge. The diversional therapist has been employed since September 2013 and has 19 years' experience. She attends the regional DT support group meetings, which provides networking and resources. The DT completes a monthly programme for the rest home/hospital, dementia and Riverside based on the resident's interests. Links are maintained with the community and residents attend the Shannon senior citizens, RSA and any other community events of interest. The residents enjoy crafts, painting, cooking, happy hour, quizzes, bowls, and reminiscing. One on one time or small group activities are carried out with the dementia residents. The programme is flexible to meet the recreational preferences of the residents. Outings are scheduled using the company van with one wheelchair access. Inter home visits are enjoyed. Riverside residents are invited to all activities and functions. The residents residing at Riverside are more independent and often choose to do their own activity. Entertainers and schoolchildren visit. Residents spiritual needs are met with inter-denominational church services weekly and visiting 7th day Adventist church groups. Volunteers are actively involved in the programme. Resident meetings are held bi-monthly with the venue alternating between Lonsdale and Riverside. Residents provide feedback and suggestions on the programme through a survey and resident meetings. Residents and relatives interviewed are satisfied with the content and variety of the activity programme and state that it has greatly improved.

There is an activity assessment for each new resident from which an activity plan is developed. This is evaluated and reviewed every six months. There are activity plans in place for the dementia care unit residents, which describe their interests and activities over a 24-hour period.

D16.5d There is a plan in place to coordinate the review of all the individual activity plans at the time of residents long-term 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.

Attainment and Risk: FA**Evidence:**

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is an initial RN and team leader assessment and this is reviewed six monthly. There is a three monthly review by the GP. There is documented evidence that care plan evaluations are up to date in seven of eight resident files sampled. One rest home resident (at Lonsdale) has not been at the service long enough for a six monthly evaluation. Care plan reviews are signed as completed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is on-going as sighted in resident files sampled. D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c; All initial care plans were evaluated by the RN within three weeks of admission</p>

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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

Attainment and Risk: FA
Evidence: The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, speech language therapist, occupational therapist and wound care nurse. 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 nurses and clinical manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, nurse practitioner intern, 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.

Attainment and Risk: FA
Evidence:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: <p>There are policies 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 transfer form 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 is made and this is documented. Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.</p>

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy is contracted to provide the medication blister packs and other pharmaceuticals. The nightshift RN checks, initials and dates the blister packs when delivered. Any discrepancies are fed back to the pharmacy. Medication trolleys are kept in locked treatment room in the rest home Lonsdale, hospital RN office and locked cupboard at Riverside. There is a designated medication fridge in the hospital unit. Temperatures are monitored and are within the acceptable range. All opened eye drops/ointments are dated on opening. Medication return bins are kept in locked areas.

There are no self-medicating residents. The care manager advised locked drawers are available for self-medicating residents.

Controlled drug (CD) safes are kept within locked areas. There is weekly CD physical check evidenced in the controlled drug register. The pharmacy is conducting controlled drug checks weekly at Riverside lodge to coincide with their weekly delivery of medications.

Medication competent staff has completed annual medication competency assessments and attend annual medication education. RN's have attended syringe driver training and annual refreshers. There is a current medication competent specimen signing sheet.

Eighteen medication charts sampled (seven hospital, five dementia, six rest home) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. Four out of eighteen medication charts had no evidence of three monthly GP reviews of medications. An improvement is required around GP three monthly medication reviews. All signing sheets are correct and prn medications are dated, timed and signed. Information available on medications for staff includes: commonly used medication guide and pharmacy guide.

There is emergency oxygen available. The regulators have been checked.

D16.5.e.i.2; 14 out of 18 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Low

Evidence:

Eighteen medication charts sampled (seven hospital, five dementia, six rest home) and signing sheets sampled identified all medication charts had photo identification and allergies/adverse reactions noted. 14 out of 18 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.

Finding:

Four out of eighteen medication charts have not been signed after a three monthly review by the GP.

Corrective Action:

Ensure the GP signs the medication chart after completing the 3 monthly medication review.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>There are food policies/procedures for food services and menu planning appropriate for this type of service. There is a qualified household manager who oversees the Lonsdale and Riverside food service, ordering of food items and staffing. The menu is four weekly rotating summer and winter. This is reviewed by a qualified dietitian twice a year, reports back and any recommendations actioned. The RN provides the cook with a resident's dietary profile on admission and informs the cook if there are any dietary changes. Resident likes and dislikes are known with alternative choices offered. Dietary needs include soft/pureed, vegetarian, diabetic and gluten free (Riverside). There are specialised lip plates and utensils as required to promote resident independence at meal times. The main meal is at midday. Meals are served from Bain Marie's in the hospital and rest home. In the dementia unit, the meal is buffet. The hot food temperature monitoring is carried out on the main midday meal. Both facility kitchens are well equipped with adequate pantry and dry good storage space.</p> <p>A nutrition and dietetic assessment is undertaken for each resident on admission. This includes likes and dislikes and special dietary requirements. Eight out of eight resident files contained the nutrition assessment in line with the care plan review. Copies are provided to the cook who keeps them in a folder. Special diets including dislikes are written on the kitchen board for quick reference. Regular monitoring of resident's weight and nutritional needs occur. Any resident who requires a special nutritional requirement is referred to a dietitian.</p> <p>Additional foods are supplied to the dementia unit fridge ensuring 24 hour availability of nutritional snacks for the residents. A fluids trolley was sighted in the hospital wing and staff observed assisting residents with drinks. Each resident had a fluid jug beside him or her in the lounge.</p> <p>Both kitchens hold at least three days of food in case of an emergency. Fridge and freezer temperatures are recorded daily and if there is evidence of a temperature recording outside of the acceptable range, it is reported to the household manager and corrective action taken. All perishable goods in the fridges are date labelled. Staff are observed wearing correct protective wear, hats, aprons and gloves. There are cleaning schedules in place. Ecolab provide the chemicals, safety data sheets and provide chemical safety training as required. Chemicals are stored safely at both kitchens. All staff have received food safety and hygiene training. Cooks have completed HSI (168) training within the last two years, and all kitchen staff have completed unit standard 167. Seven relatives/whanau (three hospital, two rest home, 2</p>

dementia) and six out of six residents (two hospital, four rest home) expressed satisfaction with food services. An internal kitchen audit is completed as part of the annual audit schedule.

E3.3f, There is evidence that there are additional nutritious snacks available over 24 hours.

D19.2; Staff have 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.

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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 are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. 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 and all were correctly labelled with the manufacturer's label. 36 staff attended chemical safety in May 2013.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The Lonsdale total care building holds a current warrant of fitness, which expires on 31/3/2014. The Riverside Lodge building of warrant of fitness expires 26/11/2014. Lonsdale is a large, spacious single story building with safe internal access between the bedrooms and communal areas. It was observed on the day of audit that the service has re-decorated much of the facility. Riverside has benefitted from refurbishment including re-decoration of the dining room and extension of a veranda for residents to walk along the front of the building. New carpet has been installed. The dementia unit has had the door to the dining area removed and the doorway widened to provide an open plan dining area and better observation from the nurses' station. Hallways are sufficiently wide enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids.

Reactive and preventative maintenance occurs. A maintenance person with a building background is employed for 25 hours per week. There is a maintenance request book for repairs and maintenance requests. Minor repairs are addressed and signed off. There is evidence of corrective action and where required preferred contractors are contacted to address repairs. Electrical equipment has been checked and tagged next due April 2014. Planned maintenance includes call bell testing weekly and hot water temperature monitoring monthly. Cleaning duties such as high ceilings are included in the maintenance duties list. The commercial cleaners are booked for carpet cleaning on a regular basis. The external areas of both facilities are well maintained with attractive gardens. A contracted gardener maintains the grounds and gardens.

ARC D15.3; There is adequate equipment available for the rest home, hospital and dementia unit. Interviews with five caregivers, three registered nurses confirmed there was adequate equipment including hoists, chair scales and pressure area resources. Clinical equipment has been calibrated. Hoists have had functional checks. The purchase of additional ultra-low beds and new hospital recliner chairs are included in the 2014 capex plan.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

E3.3e; There are quiet, low stimulus areas that provide privacy when required.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, lifting aids, wheelchairs, chair scales.

E3.3e; E3.4.c; There is a safe and secure outside area that is easy to access for dementia residents. There have been improvements made to the gardens and grounds with extension of the walking pathways, raised garden beds, garden art and additional shaded seating.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are adequate numbers of toilets and showers for each wing. All bathrooms and showers are communal. Hot water temperatures are monitored monthly. There is safe flooring, seating and hand rails appropriately placed in the shower rooms. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There are privacy locks on the doors. Residents interviewed confirmed that staff provide the resident with privacy 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the hospital wing, there is one double room, three double rooms and three rooms with three beds in each room. All hospital level residents have electric beds. The

rooms are uncluttered and contain items of resident's personal property. Residents and family/whanau are encouraged to personalise their bedrooms. In the shared rooms, there are privacy curtains around each bed. At Lonsdale on day of audit, it was observed that walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space. Residents can be safely transferred into their beds using a hoist. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists. Relatives/whanau and residents interviewed confirm their bedrooms are of adequate size and they can personalise them as they like.
Bedrooms at Riverside are single, spacious and personalised.

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: The main rest home has a small lounge and kitchen. The hospital has a large lounge and dining room. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required. Riverside lodge has a spacious dining area, main lounge, seating alcoves and sunny conservatory that allows for group and individual activities. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit has a quiet lounge and a combined lounge/dining area. 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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a laundry manual and cleaning manual that describes laundry and cleaning processes. There is a well-designed laundry with defined clean and dirty flow that ensures laundry is managed according to standards and guidelines at Lonsdale and a smaller laundry a Riversdale. Resident's laundry is laundered on site. Protective clothing is available including gloves, disposable aprons and goggles. Chemicals are stored in a locked room in laundry. An external chemical supplier provides the chemicals, product use wall charts, conduct quality controls checks and training as required. Chemicals are stored in a locked room in laundry. All chemicals are labelled with manufacturer's labels. On a tour of the facility, the carpets were noted to be clean and free from stains. There is a regular carpet cleaning service. All bedrooms, hallways and communal areas were clean and tidy in appearance. All chemicals are labelled with manufacturer's labels. Residents and relatives expressed satisfaction with cleaning and laundry services.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Fire evacuation scheme approved 26 Nov 2003 by the New Zealand Fire Service. The most recent fire drill was conducted in January 2014 with 20 staff attending. Riverside has an approved evacuation scheme dated 8 October 1999. Fire equipment testing is carried out monthly by an external contractor. Riverside fire drills are conducted March and September annually. All staff are required to attend at least one fire drill annually. Staff complete an educational questionnaire annually. There is a comprehensive emergency and disaster management plan (including pandemic planning) in place with contact numbers. Civil defence supplies are kept in an emergency equipment room and include (but not limited to); torches, batteries, radio, food and emergency menu, bottled water, gas heater and spare gas bottles. There are water tanks and bottled water. A barbeque is available. There is emergency lighting back up for up to two hours. There is a portable call bell system in all bedrooms and a call bell system in all communal areas, toilet and shower areas. The facility manager has submitted a proposal for a new call bell system that is connected to pagers. There is an after hour doorbell access. The afternoon staff conduct security checks. A security camera is to be installed following the theft of the resident lounge TV. The theft was reported to the police and the DHB. An investigation confirmed staff had taken appropriate action and the theft was linked to similar thefts in the area. Staff attended disaster management in service in February 2013. There is a first aider on duty at all times

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: All bedrooms and communal areas have large windows allowing adequate natural light. Rooms are well ventilated and windows provide natural light. There are heat vents via a gas heating system and individual radiators in resident rooms. Facility temperatures are monitored. Six residents (two hospital, four rest home) 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.

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.

The service currently has seven residents who have been assessed as requiring the use of a restraint. A monthly restraint and enabler register is maintained. There are seven bedrails and two lap belts in use.

The long term care plan includes the use of restraint, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Risks known to be associated with the use of restraint and cares to be delivered during restraint periods are required to be reflected in the care plan (link 1.3.6.1).

Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. The Restraint Coordinator role is shared by the care manager and a registered nurse. Types of restraint have been approved for use by the restraints co-ordinators.

All staff complete a restraint competency assessment annually. Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies and dementia course modules. The care manager has attended restraint education at the DHB.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator role is a shared role between the care manager and a registered nurse. The overall responsibility for restraint is included in the care manager job description. The approved restraints (bedrails and lap belts) are documented in the restraint policy.

Restraint authorisation and consent is in consultation/partnership with the resident (as appropriate) or whanau, the facility restraint coordinators and GP.

There is provision for emergency restraint following consent from family/whanau.

Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any accidents/incidents to the RN/Restraint coordinator in regards to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised.

Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least six monthly. Cares and interventions throughout the restraint episode is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents' restraint assessment

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Restraint assessments are undertaken by a registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family/whanau and GP. Three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and six monthly evaluations. All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed three monthly by the Restraint coordinator and approval group.

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

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

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinators are registered nurses with responsibility for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint consent is in consultation/partnership with the resident (as appropriate) or whanau and the facility restraint coordinator. The restraint risk assessment identifies the impact on the resident's freedom and comfort required during the period of restraint. These are not all included in the care plans (link 1.3.6.1). Families are informed of the risks associated with the use of restraint. The resident/family/whanau are offered independent advocacy. The RN may apply restraint in the case of emergencies however the family/whanau are to be consulted and the restraints co-ordinators are to be notified as soon as practical. Staff complete incident forms and report any accidents/incidents to the RN/restraint coordinator in regards to restraint use and these are discussed at the RN, staff and management meetings and corrective actions initiated. Staff document restraint episodes on monitoring forms. A restraint register is maintained.

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

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Emergency use of restraint is to be evaluated 24 hours after the episode. Written evaluations are completed by the restraint co-ordinators at least six monthly or earlier if required as part of the medical review and as part of the long term care plan review. Families are included as part of this review. Effective de-escalation strategies are reviewed by the restraint co-ordinators and RNs. The restraint co-ordinators review all restraint and enabler processes and policy at least two yearly or earlier if required.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Individual approved restraint is reviewed at least six monthly as part of the medical review and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint coordinators. Incident/accidents are reviewed by the restraint coordinators. Corrective actions are monitored. There is a monthly restraint co-ordinator report taken to the management meeting, staff meeting and RN meeting. Issues/concerns are discussed at the meetings. January 2014 meeting minutes sighted evidenced a restraint report. Restraint use is linked to the clinical audit programme with a restraints compliance audits three monthly. The restraints co-ordinators regularly check the monitoring forms for compliance.

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

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

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

- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: <p>The scope of the infection prevention and control programme policy are available. There is an infection control programme contained within the IC policy and procedure manual that is appropriate for the size and complexity of the service. The programme includes activities such as hand hygiene, internal auditing, education and surveillance and is reviewed annually as part of the quality plan. A registered nurse and the care manager share the responsibility for infection control. The overall responsibility for infection control is written into the infection control programme and the care manager's job description. Infection control is a set agenda item at on all meeting agendas. Care staff and RNs interviewed state they receive the monthly reports and are aware of trends, corrective actions and quality initiatives relating to infection control activities. The facility manager reports any significant events as necessary to the acting chief executive officer.</p> <p>Visitors are encouraged to stay away if sick. There is a staff health policy in place to ensure staff do not spread infections. The facility has signage to use for outbreaks and displays this information as needed. There is an outbreak management supply readily accessible for staff to set up bedrooms and toilets for isolation. Residents are encouraged to have a flu vaccine. Flu vaccines are offered to staff.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control co-ordinators provide a monthly report to the facility manager, household manager, administration manager and staff. Meeting minutes sighted evidence infection control is discussed at all facility meetings. The facility also has access to infection prevention and control nurses from the DHB, an external IC consultant, community nurses, nurse practitioners, GP and medlab. Internet access is available.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

D 19.2a: The organisation infection control policies and procedures are purchased from an external consultant. The policies are amended as required to meet the type of service provided. The policies and procedures are reviewed at least two yearly or earlier to reflect changes in best practice. The manual includes (but not limited to) policies on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment. There is also policy on waste disposal. Infection control procedures are included in the kitchen, laundry and the housekeeping manuals.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinators are responsible for coordinating and providing education and training to staff. The IC coordinators have attended infection control education through the DHB, hospice and external education sessions provided by infection control consultants. Annual infection control education is provided annually for

all staff (May 2013). Records of staff attendance is maintained. Staff newsletters include updates on infection control practice and any issues identified for improvement. Infection control is included in the staff orientation programme. Infection control education occurs as appropriate with individual residents.

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinators use the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Short term care plans for infections are completed and kept in the resident file until the infection has resolved. All infections are entered onto a monthly infection analysis form. A monthly report is completed by the infection control co-ordinators, which is distributed to relevant meetings. Trends and quality improvements are identified and monitored.

The service uses definitions of infections as described in RN care guides. Infection surveillance includes eye, skin, UTI, wound, chest and other infections. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Corrective actions are developed when needed and are implemented. Antibiotic use is monitored. Internal audits occur including hand hygiene six monthly, laundry and cleaning audits and infection control audit (February 2014).

Five care staff and three RN's confirmed on interview that they receive audit results and data collection of monthly infections. Infection control is discussed at staff meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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