

Golden Pond Private Hospital Limited

Current Status: 20 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

Golden Pond Home and Hospital continues to provide rest home and hospital level care, including two palliative care beds. The facility has a maximum capacity of 61 beds, including 11 studio apartments which are located within the main building. All beds can be used for either rest home or hospital care.

On the days of audit there are nine rest home level care residents and 45 hospital (including two palliative care) residents. Nine of the 11 residents occupying studio apartments are receiving either rest home or hospital level care.

This certification audit revealed two areas requiring improvement and four areas demonstrating continuous improvement. There are improvements required related to completing annual performance appraisals with staff, and more clearly identifying risks associated with restraint use.

Areas of continuous improvement are identified in the management of waste and hazardous substances, quality and risk systems, best practice, and cleaning and laundry practice. A full document review was conducted prior to the on site audit. Policies and procedures are of a good standard.

Audit Summary as at 20 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 20 March 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 20 March 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 20 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 20 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.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint Minimisation and Safe Practice as at 20 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Infection Prevention and Control as at 20 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 20 March 2014

Consumer Rights

The service has processes in place that demonstrate their commitments to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whanau wishes. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural, values and beliefs are provided at the service.

Residents receive services of an appropriate standard for rest home and hospital level of care. The service provides an environment that encourages good practice. The service has conducted a number of projects that reflect current accepted good practice; this is an area that the service has received a continuous improvement rating, above the expected full attainment. The resident, family and the general practitioner express high satisfaction with the quality of care at Golden Pond.

Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff are demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

Residents and relatives are advised on entry to the facility of the complaint process and demonstrate a good understanding of this. There is evidence that all expressed concerns and/or

formal complaints are taken seriously and acknowledged by the service, and then investigated and managed in ways that facilitate resolution between affected parties.

Organisational Management

The service is governed by the same director who established the site and services 25 years ago. The nurse manager has been employed for 17 years. The director is on site at least one day a week and supports the manager in ensuring that services are well planned and coordinated to meet the needs of all residents.

Quality and risk management systems are well established and continue to be reviewed. There is a rating of continuous improvement for ongoing adjustments to the quality system that result in better health and safety outcomes for residents and staff.

The adverse event reporting system is a planned and co-ordinated process. Staff clearly and reliably report and/or document incidents and accidents, and other adverse, unplanned or untoward events. Incidents and accidents are analysed and reviewed and then ways to reduce or prevent future incidents are discussed with staff. There are evidence families and other affected parties (eg, general practitioners) are notified of incidents where necessary, in a timely manner.

Staff are recruited, and orientated according to good employer practices. There is an improvement required to meet the aged care contract which requires all staff to participate in annual performance appraisals. All staff are supported and encouraged to attend regular education and engage in professional development. There is a clearly documented rationale for determining staff levels and skill mix in order to provide safe service delivery. Rosters and interviews demonstrate that staff are allocated according to residents' needs and that staffing meets contract requirements. Registered nurses are onsite 24 hours a day, seven days a week. A general practitioner visits one to two times a week depending on the residents' needs. There is a low staff turnover.

Resident information is uniquely identifiable and is held in a secure location and are readily accessible to staff

Continuum of Service Delivery

The service provides hospital and rest home level care to residents over the age of 65 years. Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for hospital and rest home level care and a bed is available.

The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes.

Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

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

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

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

Safe and Appropriate Environment

The buildings, chattels and equipment are well maintained and upgraded as required to increase resident safety and comfort. There is a rating of continuous improvement for the implementation of new body waste disposal systems which reduce the risk of infection for residents and staff.

The building warrant of fitness is current. Fire suppression systems are monitored and tested regularly. There is ample food and water and essential health care products stored on site to provide for 61 residents and staff for at least three days in the event of a civil emergency or power outage.

New systems for cleaning have been introduced since the previous audit. This has reduced resident and staff exposure to chemicals, increased time efficiency and is rated as continuous improvement.

Restraint Minimisation and Safe Practice

Three residents are assessed and approved for use of bed rails as restraints to prevent harm and four residents are assessed and approved to use bed rails and a lap belt as enablers. Restraint use is minimised and there is evidence that all possible alternatives are tried before implementing restraint as a last resort. There is a requirement to identify and document all possible risks associated with the restraint in use and in relation to the individual resident. Staff training in safe restraint use and restraint minimisation is occurring at regular intervals.

Infection Prevention and Control

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up.

The services policies and procedures are developed by an external specialist organisation and comply with relevant legislation and current accepted good practice.

The service provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau.

There is a monthly surveillance for infections. The surveillance data is collected, collated and analysed monthly. Quarterly benchmarking is undertaken by an external provider. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections.

HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of 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:	Golden Pond Private Hospital Ltd		
Certificate name:	Golden Pond Hospital and Rest Home		
Designated Auditing Agency:	DAA Group		
Types of audit:	Certification		
Premises audited:	47 Bracken Avenue WHAKATANE		
Services audited:	Aged Care - Hospital and Rest Home		
Dates of audit:	Start date: 20 March 2014	End date: 21 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:			54

Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	14
Other Auditors	XXXXX	Total hours on site	14	Total hours off site	10
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	4

Sample Totals

Total audit hours on site	28	Total audit hours off site	28	Total audit hours	56
Number of residents interviewed	4	Number of staff interviewed	13	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	9	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	70	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 31 March 2014

Executive Summary of Audit

General Overview

Golden Pond Home and Hospital continues to provide rest home and hospital level care, including two palliative care beds. The facility has a maximum capacity of 61 beds, including 11 studio apartments which are located within the main building. All beds can be used for either rest home or hospital care. On the days of audit there are nine rest home level care residents and 45 hospital (including two palliative care) residents. Nine of the 11 residents occupying studio apartments are receiving either rest home or hospital level care.

This recertification audit revealed two areas requiring improvement and four areas demonstrating continuous improvement. There are improvements required related to completing annual performance appraisals with staff, and more clearly identifying risks associated with restraint use. Areas of excellence and continuous improvement are identified in the management of waste and hazardous substances, quality and risk systems, best practice, and cleaning and laundry practice. A full document review was conducted prior to the on site audit. Policies and procedures are of a good standard.

Outcome 1.1: Consumer Rights

The service has processes in place that demonstrate their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whānau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whānau wishes. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural, values and beliefs are provided at the service.

Residents receive services of an appropriate standard for rest home and hospital level of care. The service provides an environment that encourages good practice. The service has conducted a number of projects that reflect current accepted good practice; this is an area that the service has received a continuous improvement rating, above the expected full attainment. The resident, family and the general practitioner express high satisfaction with the quality of care at Golden Pond.

Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whānau right to full and frank information and open disclosure from the staff are demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whānau and the community. Residents have access to visitors of their choice.

Residents and relatives are advised on entry to the facility of the complaint process and demonstrate a good understanding of this. There is evidence that all expressed concerns and/or formal complaints are taken seriously and acknowledged by the service, and then investigated and managed in ways that facilitate resolution between affected parties.

Outcome 1.2: Organisational Management

The service is governed by the same director who established the site and services 25 years ago. The nurse manager has been employed for 17 years. The director is on site at least one day a week and supports the manager in ensuring that services are well planned and coordinated to meet the needs of all residents.

Quality and risk management systems are well established and continue to be reviewed. There is a rating of continuous improvement for ongoing adjustments to the quality system that result in better health and safety outcomes for residents and staff.

The adverse event reporting system is a planned and co-ordinated process. Staff clearly and reliably report and/or document incidents and accidents, and other adverse, unplanned or untoward events. Incidents and accidents are analysed and reviewed and then ways to reduce or prevent future incidents are discussed with staff. There is evidence families and other affected parties (eg, general practitioners) are notified of incidents where necessary, in a timely manner.

Staff are recruited, and orientated according to good employer practices. There is an improvement required to meet the aged care contract which requires all staff to participate in annual performance appraisals. All staff are supported and encouraged to attend regular education and engage in professional development. There is a clearly documented rationale for determining staff levels and skill mix in order to provide safe service delivery. Rosters and interviews demonstrate that staff are allocated according to residents' needs and that staffing meets contract requirements. Registered nurses are onsite 24 hours a day, seven days a week. A general practitioner visits one to two times a week depending on the residents' needs. There is a low staff turnover.

Resident information is uniquely identifiable and is held in a secure location and are readily accessible to staff

Outcome 1.3: Continuum of Service Delivery

The service provides hospital and rest home level care to residents over the age of 65 years. Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for hospital and rest home level care and a bed is available.

The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes.

Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

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

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

Outcome 1.4: Safe and Appropriate Environment

The buildings, chattels and equipment are well maintained and upgraded as required to increase resident safety and comfort. There is a rating of continuous improvement for the implementation of new body waste disposal systems which reduce the risk of infection for residents and staff.

The building warrant of fitness is current. Fire suppression systems are monitored and tested regularly. There is ample food and water and essential health care products stored on site to provide for 61 residents and staff for at least three days in the event of a civil emergency or power outage.

New systems for cleaning have been introduced since the previous audit. This has reduced resident and staff exposure to chemicals, increased time efficiency and is rated as continuous improvement.

Outcome 2: Restraint Minimisation and Safe Practice

Three residents are assessed and approved for use of bed rails as restraints to prevent harm and four residents are assessed and approved to use bed rails and a lap belt as enablers. Restraint use is minimised and there is evidence that all possible alternatives are tried before implementing restraint as a last resort. There is a requirement to identify and document all possible risks associated with the restraint in use and in relation to the individual resident. Staff training in safe restraint use and restraint minimisation is occurring at regular intervals.

Outcome 3: Infection Prevention and Control

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up.

The services policies and procedures are developed by an external specialist organisation and comply with relevant legislation and current accepted good practice.

The service provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau.

There is a monthly surveillance for infections. The surveillance data is collected, collated and analysed monthly. Quarterly benchmarking is undertaken by an

external provider. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	3	45	0	2	0	0	0
Criteria	4	95	0	2	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	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 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an improvement required to meet the ARC requirements in D17.7 (f). Although the manager makes every attempt to complete performance reviews and appraisals with each RN and each caregiver, these are not reliably occurring each year. Five of the nine staff records sampled show that	Review the processes and resources available for engaging all staff in regular performance appraisals and implement a system that ensures these occur at least annually.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				appraisals are overdue and/or the frequency of appraisals is more than a year.		
HDS(RMSP)S.2008	Standard 2.2.2: Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 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	PA Low	The assessment process does not include identifying risks associated with the individual and/or the type of restraint in use.	Ensure the assessment procedure includes consideration and identification of any risk associated with the individual and/or the type of restraint in use.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	There are a number of examples of service and quality improvements a result of the organisations ongoing commitment to continuous quality improvements. For example a goal to prevent staff injury by providing more focused training on safe patient handling and safe use of hoists has resulted in a 50% reduction in staff injury/strains and a new system for more closely analysing skin tears and bruises has led to a reduction in preventable skin tears and bruises.
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	CI	
HDS(C)S.2008	Criterion 1.4.1.1	Service providers follow a documented process for the safe and appropriate	CI	The service has implemented a new system for disposal of body waste since the previous audit . Two 'macerators' are purchased to replace the old bed pan and urine bottle sanitisers in the sluice rooms. This minimises the risk of staff exposure to

Code	Name	Description	Attainment	Finding
		storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.		infections, and cross infection in residents as all body waste is now collected and discarded in disposable containers. The system also eliminates unwanted odours and reduces the amount of staff time spent in washing reusable items. There is also a measurable reduction in the rate of urinary tract infections (UTI). There are no UTIs reported for November and December 2013 and UTI rates are significantly lower this year compared to the previous years data. The service meets the ARC requirements.
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	CI	
HDS(C)S.2008	Criterion 1.4.6.2	The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	CI	The service is demonstrating best practice in its approach and systems for environmental cleaning. An entirely new approach to cleaning has been implemented following the infection control coordinator attended a Bug Control seminar in April 2013. Cleaning and care staff report that the new system has reduced work effort and increased cleaning effectiveness. There is a new system of colour coding, which designates four different colours of cloth, mops, buckets and gloves for different areas (eg, red for bathrooms, blue for general cleaning, yellow for infectious areas and green for food). A majority of cleaning clothes are microfiber which has reduced the necessity to use cleaning chemicals. There are also new types of gloves in general use which are not made from latex (reduces risk of allergies) are powder free and use a contamination proof system for removal of each glove. Sanitising sprays have been replaced by tuffly wipes to reduce harm by inhalation of chemicals, thereby providing a safer work place and environment for residents.

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:

As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering residents' bedrooms, use residents' preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (13 of 13 staff from across all services) confirm they respect the resident's right to refuse cares or interventions. Staff can verbalise ways they deal with situations that arise which ensure residents' rights are maintained. This is confirmed during interviews with eight of eight residents (four rest home and four hospital) and three of three family/whānau members. The general practitioner (GP) interviewed has high praise for the staff's delivery of resident care that respects the individual resident's rights.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

Opportunities are provided for explanations, discussion, and clarification about the Code of Health and Disability Services Consumers' Rights (the Code) with the resident and family/whānau as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service are clearly displayed at the entrance to the facility and available to residents and visitors. Interviews with eight of eight residents and three of three family/whānau report they are informed of their rights and that staff always respect all aspects of their rights. The advocate interviewed reports they provide both resident and staff education on advocacy, rights and complaints processes.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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>Document Review: The privacy/dignity policy describes the service expectations in regards to providing consumers physical and auditory privacy. It refers to the Privacy Act 1993 and the Health Information Privacy Code 1994. It nominates the nurse manager as a privacy officer. The Elder Abuse policy contains clear definitions and signs of all types of abuse and neglect and actions to follow if abuse is witnessed or suspected. The policy states the ways the service endeavours to protect vulnerable adults which includes staff training in elder abuse. There are clearly described policies and processes for ensuring that consumers receive services which acknowledge their intimacy, sexuality and spiritual needs.</p> <p>Stage two: The environment allows residents physical, visual, auditory and personal privacy. All rooms are single occupancy to maintain resident privacy.</p> <p>Resident's needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in eight of eight resident file reviews (two rest home and six hospital), which identify interventions put in place match identified needs.</p> <p>As observed at the time of audit services are provided in a manner that maximises each resident's independence and allows choices to be respected. The eight of eight residents and three of three family/whānau report that they are treated with respect and that resident's receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. The family added comments that they are 'amazed by the caringness' of all staff and that the service has 'exceeded all expectations' regarding the quality of care provided. One resident interviewed reports that their independence is encouraged and that they have an electric scooter so that they can go out independently.</p>

ARRC requirements are met.

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

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

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

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

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

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

Document Review: The Maori Health Plan is extensive and provides clear guidance on service provision that is culturally sensitive and appropriate to the needs of Maori consumers. The plan includes a history of Eastern Bay of Plenty tangata whenua, the social makeup of the area; it recognizes the Treaty of Waitangi and describes principles of care and outcomes and how to recognise Maori values and beliefs according to Te Whare Tapa Wha (the four corner stones of Maori health.) The procedures describe Tikanga recommended best practices for all aspects of care including death and how to support and manage Maori people with dementia.

Stage two: Māori residents have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. The manager reports there are no barriers to Māori accessing the service, and there are a number of Māori residents and staff at the service. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interviews with seven care staff (four RNs and three caregivers) from across all services. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. The file of a resident, who identifies as Māori, records the resident's iwi and describes the importance of whanau. The Māori resident's file reviewed demonstrates the resident receive services commensurate with their needs (confirmed at interview with care staff and the resident).

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Document Review: The cultural safety policy provides clear guidelines to ensure each resident's own culture and identity is not risked. Policy states 'Residents will not be discriminated against on the grounds of race, colour or ethnic origin and all residents will have equal access to Golden Pond facilities and services. There are clear descriptions on how to ensure care planning includes cultural values and beliefs.

Stage two: Interviews with eight of eight residents and three of three family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care plan (as sighted in eight of eight resident file reviews).

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Nine of nine staff record reviews identify that staff sign a code of conduct that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with 13 of 13 staff, eight of eight residents, one GP, and three of three family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation.

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

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

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: CI

Evidence:

There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interviews with the 13 of 13 staff confirm that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. The service has conducted a number of projects related to waste disposal, cleaning products, personal protective equipment, wound care and falls management that are researched to current accepted good

practice. Refer to continuous improvement rating at criteria 1.1.8, 1.2.3.6 and 1.4.1.1. Interviews with eight of eight residents, three of three family/whānau and the GP confirm their high level of satisfaction with all care delivery and staff attitudes. This is further supported by the results of the recent resident satisfaction survey.

ARRC requirements are met.

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

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

Attainment and Risk: CI

Evidence:

The service has conducted a quality review project on falls minimisation based on evidenced-based practice on falls prevention and awareness. A literature review of best practice in falls prevention was conducted. The documented project summary includes the shortfalls that were identified in the services falls prevention strategies, review of falls data and how the falls strategies are monitored. The project has documented aims to set a falls minimisation programme. The service set a formalised falls minimisation programme, adapted best practice in looking at clinical pathways for falls minimisation, adapting a clinical pathway for patient handling, identifying risk factors, falls recording reporting and education of staff with the introduction of the formal falls minimisation programme. When a fall has occurred, there is a review process for each individual, a falls assessment, and falls minimisation strategies are evaluated and preventative measures are reviewed. Though the review of the implementation is ongoing, the documented feedback and summary of the programme in March 2014 records that there has been an improvement in patient safety. The service has also conducted similar projects related to bruising; skin management; and environmental cleaning (also refer to criteria 1.2.3.6 and 1.4.1.1).

Finding:

The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.

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:

Policy related to open disclosure is implemented by the service. Interviews with three of three family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family/whānau communication is clearly documented in the eight of eight resident file reviews, on incident and accident forms sighted and in the staff communication book. The family/whānau and patients interviewed report that communication is strength of the service.

Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. At the time of audit there are no residents who require interpreter services.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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>Document Review: The informed consent policy provides clear detail on how to meet best, safe practice and rights 5, 6 and 7 under the Code of Health and Disability Services Consumer Rights('the Code') 1996. There are specific guidelines for obtaining informed consent and advance directives which discuss voluntary and competent consent and states that advance directives will be reviewed on a regular basis.</p> <p>The Resuscitation policy states 'In the event of illness or deterioration medical and nursing assessment and intervention is sought with the emphasis on relief of symptoms, maintenance of comfort and ensuring dignity is preserved along with involvement from family or whanau. In the event of cardiac and respiratory collapse, CPR will be a clinical decision unless stated on the advanced care plan. This policy may be discussed at pre-entry and on the day of admission'</p> <p>Stage two: Signed consent forms are sighted in the eight of eight residents' files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with eight of eight residents and three of three family/whānau members. The eight of eight residents' files reviewed have correctly signed advanced directives or an advanced care plans identifying the resident's chosen wishes related to resuscitation status and end of life care. The seven of seven clinical staff demonstrate their understanding of acting on valid advance directives.</p> <p>ARRC requirements are met.</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: <p>The eight of eight residents' files reviewed, interviews with eight of eight residents and three of three family/whānau confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family/whānau members confirm their awareness of where to locate the information. A phone interview with an advocate from the Nationwide Health and Disability Advocacy Service is conducted, and they have recently worked through an issue the residents have raised, with a successful outcome from this (documented in the complaints register). The advocate conducts regular in-service education for both residents and staff.</p> <p>ARRC requirements are met.</p>

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Interviews with eight of eight residents confirm they have access to visitors of their choice. The three of three family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.

Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in eight of eight residents' files identifies that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. For example weekly RSA visits regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended service in the community. One resident interviewed said that they go into town regularly on their motorised scooter. The service also has links with community services, such as the Stroke Club, who have weekly groups at the service. On the days of audit the residents went out both days to partake in community and family activities.

ARRC requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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
Evidence: <p>Document Review: The concerns/complaints policy and associated forms contain clear processes, timeframes and information that meet the requirements of this standard, the ARC contract, and right 10 of the Code. There are clear references to advocacy with contact numbers for independent advocates and the HDC</p> <p>The sighted complaints register contains a clear account of all complaints, concerns and compliments received since the previous audit. There is evidence in the records that concerns and complaints are acknowledged in writing and investigated within an appropriate timeframe and that all parties are kept informed at all stages of the process. The register records dates and comments that all complaints are resolved. There have been no known complaints to the Office of the Health and Disability Commissioner but a complaint from residents in February 2014 involved the local advocate from the Nationwide Health and Disability Advocacy Service. The matter is resolved and there is ongoing contact and monitoring to ensure the problem does not recur. This is confirmed by the independent advocate interviewed by telephone who also expressed confidence in the way the service engaged with and responded to the situation.</p>

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:

Document Review: The service mission statement, purpose, values, organisational philosophy, direction and goals are clearly documented in the annual business and quality plan. There are also referred to in the resident information booklet.

The nurse manager has been in the role for 17 years and maintains a nurse practicing certificate and her nursing portfolio. She attends regular professional development, at least eight hours a year in education related to the role of manager and regular clinical updates (sighted education and conference/seminar attendance records).

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

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

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

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 clinical nurse manager is the substitute manager for planned and unexpected absences of the manager. This person is suitably qualified and experienced. The same system in place for 15 years has proven to be efficient and effective. This is confirmed by interview with the director, nurse manager and clinical nurse manager.

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

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:

Document Review: The submitted quality plan contains four goals and the documented quality/risk management principles provide adequate description of the quality system and quality monitoring methods in place. The risk management plan 2014 and occupational health and safety processes, contain clear descriptions of actual and potential risks, actions and controls for each of these along with the people and regularity of monitoring/review or reporting. There are separate hazard registers for service areas. There is a nominated Health and Safety Officer/OSH nurse and terms of reference for care meetings where provision of resident care and health and safety discussions occur. There is a clearly described policy on policy control, development and review.

The service regularly seeks resident and family feedback in one to one discussions, care review meetings and via annual satisfaction surveys. Results of the most recent reviews (July 2013 resident and Feb 2014 family surveys) show high satisfaction with services. The surveys include questions on all aspects of the consumer code, satisfaction with the services provided, activities, privacy, cultural responsiveness, food satisfaction, medical services, and cleanliness of the facility. There were no areas identified as requiring improvements from these surveys.

Quality data (complaints, infections, health and safety/near miss/hazard reporting and restraint and adverse events) are collected, analysed and reported regularly. These are all used as performance indicators in the annual quality/ risk management plan. There is a well-established internal audit schedule and results of audits are communicated to staff (as evidenced in sample of meeting minutes and confirmed in interview with 13 staff from different disciplines and shifts).

A process to measure achievement against the quality and risk management plan is in place. This includes the nurse manager completing a narrative report about all service areas (safe staffing, OSH and staff injury, pressure areas, medicine, staff education, resident infections, resident falls and challenging behaviour/restraint) each year. The internal audit programme is closely linked to the service quality and risk management system. Results of internal audits are discussed with staff at the monthly care committee meetings and at the restraint and behaviours of concern group meeting. Minutes from these meetings and the results of audits are also displayed in the staff room. All staff are invited to attend these meetings and there is compulsory representation from each service area. The results of internal audits are used to guide quality and risk management improvements (as evidenced by interview with the nurse manager and clinical manager).

Where areas for improvement are identified by audits, incidents, consumer or family feedback, a continuous improvement form is documented and monitored for implementation by the manager (confirmed by manager and director interview and a sample of quality improvement forms sighted). Corrective actions are also documented in audit records, in the complaint register and on incident forms. Areas for improvement and new ways to mitigate risk are discussed at staff meetings as confirmed by staff interview.

Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the link to associated legislation, the risk rating, the controls and actions that have been put into place to prevent the risk from re-occurring and/or how to deal with the risk in the event of its re-occurrence, and the person(s) responsible. Hazards are identified on the hazard register. A copy of the hazard register is posted in a visible location at reception. New hazards are identified on the hazard identification summary form (also posted at reception). The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).

There are a number of examples of service and quality improvements a result of the organisatio'ns ongoing commitment to continuous quality improvements. For example a goal to prevent staff injury by providing more focused training on safe patient handling and safe use of hoists has resulted in a 50% reduction in staff injury/strains and a new system for more closely analysing skin tears and bruises has led to a reduction in preventable skin tears and bruises.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: CI
Evidence: The organisation has well established quality monitoring systems. Quality data (complaints, infections, health and safety/near miss/hazard reporting and restraint and

adverse events) are collected, analysed and reported regularly. These are all used as performance indicators in the annual quality/ risk management plan. There is a well-established internal audit schedule and results of audits are communicated to staff (evidenced in sample of meeting minutes and confirmed in interview with staff from different disciplines and shifts).

There are a number of examples of service and quality improvements a result of the organisation's ongoing commitment to continuous quality improvements. For example a goal to prevent staff injury by providing more focused training on safe patient handling and safe use of hoists has resulted in a 50% reduction in staff injury/strains and a new system for more closely analysing skin tears and bruises has led to a reduction in preventable skin tears and bruises.

Finding:

There are a number of examples of service and quality improvements a result of the organisations ongoing commitment to continuous quality improvements. For example a goal to prevent staff injury by providing more focused training on safe patient handling and safe use of hoists has resulted in a 50% reduction in staff injury/strains and a new system for more closely analysing skin tears and bruises has led to a reduction in preventable skin tears and bruises.

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Document Review: The untoward and adverse event policy, proforma and policy on incident form submitted contain clear guidelines for reporting incidents. These describe an open disclosure process.

Adverse events (eg, falls, skin tears, pressure areas, infection rates, medicine errors, and drug reactions) are documented by the individual who witnesses the event and are considered by the Nurse Manager or Clinical Nurse Manager for follow up and/or sign off the next day. Results are analysed for trends and reported monthly by the Nurse Manager to the Director. Results are shared with staff at monthly care meetings and falls are reported to the restraints monitoring and behaviours of concern group. The new approach to falls prevention and management which was implemented in 2012 continues to be an area of focus. The falls prevention programme is proving to be effective and residents' falls are reduced. There is a rating of continuous improvement for this is standard 1.1.8

The nurse manager completes an annual summary report of medicine errors. This report (sighted for 2013) documents comparative data, discusses where errors could have been prevented and reports on the effectiveness of the corrective actions implemented to reduce medicine errors.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>The reviewed policies and procedures in relation to Human Resources Management comply with employment legislation.</p> <p>The skills and knowledge required for each role is documented in job descriptions which outline accountability, responsibilities and authority (confirmed by review of nine staff files along with employment agreements, completed police checks, orientation and competency assessments). The service ensures that staff who require ongoing membership with their professional bodies maintain these memberships. A file containing copies of all the RN's current annual practising certificates, podiatrists registration and GP and pharmacist registration are sighted.</p> <p>The staff training plan and attendance records sighted, provide evidence that ongoing education is provided in subject areas relevant to the services provided. The training programme is overseen by a dedicated training co-ordinator who is an ACE assessor and an enrolled nurse. The programme includes education being provided by external trainers and staff completing competency questionnaires. Medicine competency assessments occur at the same time each registered nurses or enrolled nurse renews their practising certificate. Education topics include, continence management, pain management, management of challenging behaviour and de-escalation, personal grooming and hygiene, skin management and wound care, abuse and neglect, the aging process, cultural training, consumer rights, privacy, informed consent, and infection control. The staff records reviewed (a sample of nine and their individual education files) show that training is occurring and training records are regularly updated for all staff. All 13 staff interviewed confirm their attendance at ongoing in-service education.</p>

The ARC contract requirements for staff training are met.

All new staff engage in an orientation/induction programme which covers the essential components of the service provided and is specific to the role employed for. The programme includes information about the organisation, emergency preparedness, the quality and risk systems, policies and procedures, health and safety requirements, restraint and infection control, the physical layout of the facility, authority and responsibility of the individual's positions and tasks specific to the role.

There is an improvement required to meet the ARC requirements in D17.7 (f). Although the manager makes every attempt to complete performance reviews and appraisals with each RN and each caregiver, these are not reliably occurring each year. Five of the nine staff records sampled show that appraisals are overdue and/or the frequency of appraisals is more than a year.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The staff training plan and attendance records sighted, provide evidence that ongoing education is provided in subject areas relevant to the services provided. The training programme is overseen by a dedicated training co-ordinator who is an ace assessor and an enrolled nurse. The programme includes external speakers and completing competency questionnaires. Medicine competency assessments occur at the same time each registered nurses or enrolled nurse renews their practicing certificate. Education topics include, continence management, pain management, management of challenging behaviour and de-escalation, personal grooming and hygiene, skin management and wound care, abuse and neglect, the aging process, cultural training, consumer rights, privacy, informed consent, and infection control. The staff records reviewed (a sample of nine and the education files) show that training is occurring and individual training records are maintained for all staff. 13 staff interviewed confirm their attendance at ongoing in-service education. The ARC contract requirements for staff training are met.

There is an improvement required to meet the ARC requirements in D17.7 (f). Although the manager makes every attempt to complete performance reviews and appraisals with each RN and each caregiver, these are not reliably occurring each year. Five of the nine staff records sampled show that appraisals are overdue and/or the frequency of appraisals is more than a year.

Finding:

There is an improvement required to meet the ARC requirements in D17.7 (f). Although the manager makes every attempt to complete performance reviews and appraisals with each RN and each caregiver, these are not reliably occurring each year. Five of the nine staff records sampled show that appraisals are overdue and/or the frequency of appraisals is more than a year.

Corrective Action:

Review the processes and resources available for engaging all staff in regular performance appraisals and implement a system that ensures these occur at least annually.

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

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

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

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

Attainment and Risk: FA

Evidence:

Document Review: There is a staffing requirements policy which clearly describes a rationale for staffing based on DHB contract requirements and a range of factors to consider in meeting safe and suitable staffing.

The staff mix and allocation of caregivers and RNs in each wing is determined by resident acuity. The service uses safe age care indicators to determine the number of staff employed and this is audited twice a year.

The full-time nurse manager works Monday to Friday 8 am to 4.30 pm and the clinical nurse manager works 32 hours per week on day shifts.

Rosters reviewed and staff, management and resident and relative interviews confirm that sufficient numbers of skilled and experienced staff are available to meet the needs of residents.

There are at least 10 caregivers and four RNs on site each week day, with three RNs during the weekend and another RN on call 24 hours a day seven days a week. This includes a dedicated caregiver and cleaner rostered to provide care and service to people living in the attached apartments. There are at least two RNs and eight care staff each afternoon with an additional 5 pm to 9 pm caregiver. Night Shift has one RN and three care staff.

Auxiliary staff (eg, gardening/maintenance, cleaning, laundry and food services) are employed for an appropriate number of hours each day. Two activities officers are on site, five days a week on a split shift (eg, one works 8 am to 2 pm and one works 1 pm to 4 pm). A contracted general practitioner (GP) visits once a week. Where resident volumes or acuity is high the frequency of GP visits increases to twice a week.

Thirteen (13) staff including five RNs, three caregivers and five auxiliary staff interviewed (who work different shifts) report there is adequate staff available and that they are able to get through their work.

The service meets the ARRC requirements in regards to staffing.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The eight of eight residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas in the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made at least daily which record the staff members name and designation. The eight of eight residents' files reviewed evidence that all records pertaining to individual resident are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records.

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

Evidence:

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, their family/whānau of choice where appropriate, local communities, and referral agencies. The service offers rest home and hospital level of care. The service has a pre-entry form which identifies the residents required level of care.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

When entry to the service has been declined, the potential resident and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services. The pre-entry form records the reason for declining, contact with the client/family and alternative options discussed. The clinical nurse manager reports that where a resident has had an appropriate assessment and there is an available bed, no residents have been declined entry.

The sighted admission agreement contains sections on the conditions in which the agreement can be terminated and changes to the level of care. The services will ensure that if they are no longer able to meet the needs of the resident (eg, require secure dementia level of care) there will be an appropriate reassessment, the service will assist to find an alternative service provider and ensure the transfer occurs in an appropriate and timely manner.

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; D16.5c; 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:

Document Review: The policies submitted which describe the management of continence, challenging behaviour, personal hygiene and grooming, skin integrity, wound care, death and dying, pain and falls prevention meet the requirements of the ARC contract. All of these clinical management policies describe using specific assessment tools and monitoring at appropriate frequencies. There is reference to short term care plans and where to seek additional advice or input.

Stage two: 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. The RNs are responsible for assessment, planning, provision, evaluation, review, and exit, with consultation with the caregivers, activities staff, and GP and family/whānau communication. The main provision of care is provided by caregivers. Annual practising certificates are sighted for all staff that require them. The GP expressed high praise for the clinical skill and clinical judgement of the nursing staff. All residents and family/whānau express high satisfaction with the care and services provide at Golden Pond. One family member expressed that the service has 'exceeded all expectations' in the quality of care and the caring and friendly nature of all staff.

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. The service uses the electronic interRAI and related Momentum Healthware for the care plan. The service has additional assessment and care plan tools for wound care, short term care plans, falls management and social and activities assessments. The assessments and outcome scales sighted in the eight of eight residents' files identifies the needs and level of dependency. The care plans are based on the assessed needs of the resident. The sighted care plans in the eight of eight residents' files reviewed identified personal, physical, psycho-social, spiritual and cultural needs of the resident. As a continuous improvement action, the outcome of the review of the incidents related to bruising and skin tears has seen the service introduce a recording sheet that summaries bruising and skin tears. This records the actions and preventive actions that can be implemented.

The eight of eight residents' files evidence that the initial assessment and initial care plan are conducted on admission, with the long term care plan is developed within three weeks of admission. The assessment, outcomes scales and care plan are reviewed and updated at least six monthly. Where required the residents are reviewed by a GP within two working days of admission, then at least monthly or three monthly where assessed as stable.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Each shift has a verbal handover and there is a written handover sheet which identifies care requirements including any required changes. Daily entries into resident progress notes record care provided and any additional changes that may be required. The seven of seven care staff interviewed (four RNs and three caregivers) report they receive adequate information at hand over. When a short term care plan is started, there is a sticker placed in the resident's progress notes to alert the staff member to read the short term care plan.

Tracer example one – rest home level of care.

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

Tracer example two – hospital level of care.

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

The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for care planning and service delivery. The service uses the interRAI electronic assessment process. The eight of eight residents' files reviewed have the interRAI assessment completed to develop the long term care plan and reassessment occurs at least six monthly, or earlier if there is a change in the residents' needs. The service also utilises other appropriate assessment tools and clinical pathways when these are not covered in the interRAI assessment process. These include wound assessment and falls assessment (also refer to continuous improvement rating at 1.1.8).</p> <p>The relevant ARRC requirements are met.</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:

The service uses an electronic care plan that is generated from the needs that are identified through the interRAI assessment process. The long term care plan, short term care plan and clinical pathways identify the supports and interventions to achieve desired outcomes, confirmed in the eight of eight residents' files reviewed (two rest home and six hospital). Both the rest home resident and hospital level of care residents reviewed have care plans and short term care plans that described the required interventions. The eight of eight residents' files reviewed identify that care planning is individualised to reflect resident's assessed needs and interventions and support systems are clearly shown. Interventions are detailed and interviews with the seven of seven care staff confirm the information ensures continuity of care. Interviews with eight of eight residents, three of three family/whānau and the GP report care is provided by staff that have excellent knowledge and skills.

The eight of eight residents' files reviewed demonstrate service integration. Residents have one main folder that contains their medical information, nursing assessment, care plan, routine observations, activities, therapies, multidisciplinary reviews, correspondence including off site consultations. The electronic records are printed and a copy is maintained in the resident's folder.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <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: FA
Evidence:
<p>The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The eight of eight care plans reviewed confirm care planning is individualised and personalised to be a true reflections of residents' assessed needs. The care plans are generated from the electronic interRAI assessment. When required additional short term care plans or clinical pathways are utilised where there is a specialised need (eg, falls minimisation, end of life care). As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions. One family commented how flexible the care is, and gave an example of when their relative was restless and awake in the early hours of the morning, and the staff 'went the extra mile' to make their relative comfortable and nothing was a problem'. The GP reports high praise for the clinical knowledge and level of care provided at Golden Pond.</p> <p>Interviews with three of three caregivers confirm they use documented interventions to provide appropriate care for each resident. If an intervention is not working well it is reported to the RN or clinical nurse manager evaluates the resident's progress and resources current accepted best practice to assist in resolving any issues. The clinical nurse manager reports that best practice projects have commenced for falls minimisation, bruising and skin tears (refer to criteria 1.1.8.1 and 1.2.3.6). The clinical nurse manager also gave an example of a tracking wound that a resident was admitted with, and the clinical team have attended further education on the best treatments for</p>

this type of wound. The eight of eight resident and three of three family/whānau confirm they are highly satisfied with care and interventions provided by the service. Residents stated all their needs are met. Comments from residents include 'care has exceed expectations', ' all the staff are fantastic', the management 'are always approachable' and 'if you ask for anything it is just done, nothing is a problem'.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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:

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. There are two activities coordinators, who work split shifts five days a week. The activities coordinator reports that they gauge responses and review the attendance records in assessing if the residents are interested and engaged in the activities. The group and individual activities are based on what the resident wants to do. The residents' meeting provides opportunities for the resident to provide feedback regarding the activities programme. The eight of eight residents express satisfaction with the activities programme.

The eight of eight residents' files reviewed have activities and social assessments. Daily activities attendance sheets are maintained and reviewed at the end of each month to assess the enjoyment and interests of the residents. The goals are updated and evaluated in each resident's file six monthly. A monthly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities. Residents are also observed at the time of audit to be engaging in

independent activities, such as going out into the community, reading, listening to music and doing exercises. There are church services weekly at the facility. Residents can access community activities, such as the Stroke Club run activities at the service weekly.

The ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans or clinical pathways. Short term care planning is sighted for infections, falls minimisation, acute conditions and wound care as confirmed in both residents reviewed. The short term care plans document the interventions are analysed, reviewed, discussed with the resident and family/whānau and evaluated for achievement towards clearly set out goals. If the interventions are not working well they are changed and staff are informed. The eight of eight residents and three of three family/whānau interviews confirm that they have very high satisfaction with the care provided at the service and that they feel fully involved and informed related to care planning and interventions that are put in place. Family/whānau report that communication is very good and all evaluation processes are explained in a manner that they understand and can have input into as appropriate.</p> <p>The interRAI assessment and outcomes measures are reviewed and evaluated at least six monthly or sooner if there are changes to the resident's needs. An evaluation of the resident's response to care is conducted, with new goals and interventions to meet these goals set at least six monthly. Though the evaluation of the care is not in a specific section on the care plan or clearly documented like the services short term care plan and clinical pathways, embedded within each interRAI instrument are various</p>

scales, indicators and outcome measures that can be used to evaluate the resident's current clinical status.

With each reassessment the data is collected and changes in the resident's clinical status are evaluated and compared. The outcome measures sighted in the eight of eight residents' files reviewed have outcome measures that are used as the evaluation of progress towards meeting desired outcomes for: activities of daily living, aggression scale, body mass index, changes in health, end stage diseases, signs and symptoms (CHESS Score), cognitive performance scale, communication scale, depression rating scale, pain scale and pressure ulcer risk.

The ARRC requirements are met.

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

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

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

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

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

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

Timeframe (days): (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:

Referrals are made to other medical services by the RN or GP as appropriate. Records of referrals sighted in the eight of eight residents' files reviewed. Health services accessed include general medicine, surgical services, cardiology, radiology, dietitian, mental health, ophthalmology, immunology and oncology. The GP confirms that appropriate referrals to other health and disability services are well managed at the service. The GP reports that the nursing staff have very good clinical knowledge and skills. The hospital level of care resident interviewed clearly confirms appropriate referrals for the resident's chronic and acute conditions.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

Risks are identified prior to planned discharges (confirmed by interview with clinical nurse manager and four RNs). There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family/whānau or resident want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision and intervention requirements is sent with the resident as appropriate. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place. The services transfer process is confirmed in the file of the hospital level of care resident reviewed .

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Document Review: There are a range of medicines policies that contain clear descriptions of processes for all stages of medicine management which meet current best, safe practice. The policy references current guidelines and legislation. Policies include guidelines on robotic system, acquisition and storage of medicines, controlled drugs, self-administration, safe administration of medicines and standing orders. The standing orders policy lists the medicines approved, dosage and frequency and states these are reviewed annually by a general practitioner. There is also policy on medicine changes and medicine errors/mishaps. The documented administration medication competency for RN's includes all expected topics.

Stage two: The service implements the medicine management process according to the policy and procedures. A safe medicine management system is observed at the time of audit (observed a RN administering the medicines).

The medicines are dispensed by the pharmacy in the robotic sachet system. The sachets are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines) are individually supplied for each resident. The sachets and all medicines are checked for accuracy against the prescription by the RN when they are administered. The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly which he signs for on the resident medication chart. The GP conducts a review of the resident's medicines at a minimum of three monthly which he signs for on the resident's medication chart. Standing orders seen are signed by the GPs in the last 12 months

All medicines and the medicine trolley are stored in the locked medication room. The medicine fridge is monitored for temperature daily. Controlled drugs are stored in a safe in the medication room and are signed out by two staff when given. A weekly stock count is recorded in the controlled drug register. Sample signature verification is recorded for all staff who administers medicines.

A review of 16 of 16 medicine charts identifies that each medication is signed for by the GP. All prescriptions are computer generated by the pharmacy and they allow a safe medication administration process to be undertaken by staff. The prescriptions are legible, record the name, dose, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify resident allergies and have a current photograph of the resident for identification purposes.

The RNs are responsible for medicine administration at the service. All RNs have a medicine competency annually (as sighted in the RN staff files reviewed).

Three of the 16 medicines charts reviewed are of residents who self-administer all or some of the medicines (eg, inhalers). Documented competencies are sighted in these residents' files, with reassessment of competency for self-administration conducted at least six monthly.

ARRC requirements are met.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: Document Review: There is a range of food service policies which contain detailed information about nutrition and menu planning, safe food handling and storage. Policy states that meal choices and the menu will be reviewed annually by a registered dietician. Stage two: The menu is last reviewed May 2012 by a registered dietitian using the menu audit tool for aged care facilities. The menu is a four week rotational menu with seasonal variations (eg, summer and winter menu). The recommendations from the menu review have been implemented. Every resident has a dietary review on entry to the service and all residents are routinely weighed at least monthly, and more frequently when indicated.

Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The diabetic and texture modified diets are clearly specified.

Interviews with eight of eight residents confirm they are satisfied with the food service and that their likes and dislikes are catered for. They report that if there is something they don't like, there are always alternatives offered. Three of three family/whānau members said the food service caters for all their relatives needs and changes to dietary requirements are always fully explained. The resident satisfaction survey conducted in May 2013 records all residents rated the food service as above average, with high satisfaction recorded for the time given to eat meals.

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

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: CI
Evidence: Document Review: The waste management policy contains clear guidelines about all types of human and domestic waste and the correct disposal methods. The prevention of waste and hazardous incidents policy describes control methods to prevent accidents and there are separate detailed policies on the use of PPE, labelling and storage of chemicals and control of spills. Material Safety Data sheets are located in each of the two sluice rooms and in the cleaners cupboard where chemicals are stored. These are accessible for staff. The

hazard register is current and contains all potential and actual hazards. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. This is confirmed by review of nine staff records and interview with 13 staff.

Visual inspection of all areas in the facility reveals that protective clothing and equipment (eg, goggles/visors, gloves, aprons, footwear and masks) for staff use is provided and conveniently located. Hazardous substances are correctly labelled and the container is appropriate for the contents, including container type, strength and type of lid/opening.

The service has implemented a new system for disposal of body waste since the previous audit. Two 'macerators' are purchased to replace the use of bed pan and urine bottle and sanitisers in the sluice rooms. This minimises the risk of staff exposure to infections, and cross infection in residents as all body waste is now collected and discarded in disposable containers. The system also eliminates unwanted odours and reduces the amount of staff time spent in washing reusable items. There is also a measurable reduction in the rate of urinary tract infection. There were no urinary tract infections (UTIs) reported for November and December 2013 and UTI rates are significantly lower this year compared to the previous years data.

The service meets the ARC requirements.

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: CI

Evidence:

Visual inspection of all areas in the facility reveals that protective clothing and equipment (eg, goggles/visors, gloves, aprons, footwear, and masks) for staff use is provided and conveniently located. Hazardous substances are correctly labelled and the container is appropriate for the contents, including container type, strength and type of lid/opening.

The service has implemented a new system for disposal of body waste since the previous audit. Two 'macerators' are purchased to replace the old bed pan and urine bottle sanitisers in the sluice rooms. This minimises the risk of staff exposure to infections, and cross infection in residents as all body waste is now collected and discarded in disposable containers. The system also eliminates unwanted odours and reduces the amount of staff time spent in washing reusable items. There is also a measurable reduction in the rate of urinary tract infection; there were no urinary tract infections reported for November and December 2013 and UTI rates are significantly lower this year compared to the previous years data.

Finding:

The service has implemented a new system for disposal of body waste since the previous audit. Two 'macerators' are purchased to replace the old bed pan and urine bottle sanitisers in the sluice rooms. This minimises the risk of staff exposure to infections, and cross infection in residents as all body waste is now collected and discarded in disposable containers. The system also eliminates unwanted odours and reduces the amount of staff time spent in washing reusable items. There is also a measurable reduction in the rate of urinary tract infections (UTI). There are no UTIs reported for November and December 2013 and UTI rates are significantly lower this year compared to the previous years data.

The service meets the ARC requirements.

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:
Document review: The transport policy provides clear guidelines on the safe transportation of residents
There is evidence of appropriate systems in place to ensure residents' physical environment and facilities are fit for their purpose. Planned and reactive maintenance occurs on buildings, plant and equipment to ensure these are maintained to an safe standard. There is a current Building Warrants of Fitness which expires 01 June 2014. Corridors in all parts of the facility are sufficiently wide to allow residents safe mobilisation, safety rails are secure and appropriately located, and there are minimal changes in floor surface and levels. Floor surfaces/coverings are appropriate to the consumer group and setting and are maintained in good order. All external areas are safely maintained and are appropriate for older people. Residents are protected from risks associated with being outside (eg, non slip pavement surfaces, safe and adequate seating, extensive shading and shelter is available for recreation or evacuation purposes).
Staff attend regular education in the safe use of medical equipment by suitably qualified personnel, and there is a system in place to review staff competency for specific

equipment such as use of hoists. This is confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, that equipment is checked before use and that they are competent to use the equipment.

Residents and relatives interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned and that the accommodation meets their needs.
The facility meets the ARC requirements.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: <p>Toilet, shower and bathing facilities are of appropriate design and number to meet the needs of residents. The majority of bedrooms have either shared or single ensuite bathrooms. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at consumer outlets monthly and monitoring records show these are within a safe range (no higher than 45 degrees Celsius). The requirements of the New Zealand Building Code are met. Toilet and showers allow for use of mobility aids and provide working space for two to three care staff if required. Communal toilet/shower/bathing facilities have safe locking systems to provide for privacy but allows service providers access in the case of emergency. Appropriately secured and approved grab rails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote consumer independence. All residents interviewed expressed satisfaction with their facilities.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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: All bedrooms are single occupancy. There is plenty of space in each bedroom to allow residents and staff to move around with equipment in the room safely. There have been no incidents with equipment or as a result of space or clutter in bedrooms.

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 maneuver 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: Visual inspection evidences adequate access is provided to the lounge, dining and other communal areas in the facility and that residents are able to move freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

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: CI

Evidence:

Document Review: There is a suite of laundry and cleaning policies which detail the tasks and standards for safe and hygienic practice. There are clear procedures for handling used and soiled laundry and lists of the cleaning chemicals to be used in each area.

Three staff interviewed demonstrate knowledge and understanding about policies and procedures. Material safety data sheets for all chemicals in use are accessible and located where chemicals are stored. All chemicals and cleaning products are safely and securely stored when not in use and staff stay within arm's length of cleaning trolleys.

Residents and their families interviewed expressed satisfaction with cleaning and laundry services. The effectiveness of cleaning and laundry services is audited regularly. There are adequate facilities and systems for the disposal of soiled water/waste (eg, sluice room, conveniently placed hand washing stations). All storage areas inspected are maintained as clean, orderly and hygienic.

Staff training files and interview with two cleaners and the housekeeper who oversees cleaning and laundry confirmed attendance at chemical safety education.

There are improvements in the methods and resources used for cleaning. A new system of color coding, which designates four different colors of cloth, mops, buckets and gloves for different areas (eg, red for bathrooms, blue for general cleaning, yellow for infetctious areas and green for food). A majority of cleaning clothes are microfibre which has reduced the necessity to use cleaning chemicals. There are also new types of gloves in general use which are not made from latex (reduces risk of allergies) are powder free and use a contamination proof system for removal of each glove. Sanitising sprays have been replaced by tuffy wipes to reduce harm by inhalation of chemicals, thereby providing a safer work place and environment for residents.

Cleaning and laundry services exceed the ARC requirements.

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: CI

Evidence:

The service is demonstrating best practice in its approach and systems for environmental cleaning. An entirely new approach to cleaning has been implemented following the infection control coordinator attended a 'Bug Control' seminar in April 2013. Cleaning and care staff report that the new system has reduced work effort and increased cleaning effectiveness.

Finding:

The service is demonstrating best practice in its approach and systems for environmental cleaning. An entirely new approach to cleaning has been implemented following the infection control coordinator attended a Bug Control seminar in April 2013. Cleaning and care staff report that the new system has reduced work effort and increased cleaning effectiveness. There is a new system of colour coding, which designates four different colours of cloth, mops, buckets and gloves for different areas (eg, red for bathrooms, blue for general cleaning, yellow for infectious areas and green for food). A majority of cleaning clothes are microfiber which has reduced the necessity to use cleaning chemicals. There are also new types of gloves in general use which are not made from latex (reduces risk of allergies) are powder free and use a contamination proof system for removal of each glove. Sanitising sprays have been replaced by tuffy wipes to reduce harm by inhalation of chemicals, thereby providing a safer work place and environment for residents.

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor

identification requirements appropriate to the consumer group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

The New Zealand Fire Service approved the fire evacuation scheme in July 2006. Trial fire evacuations occur six monthly. An evacuation and training session with the fire service was last held on 23 January 2014. Fire suppression systems are checked monthly by an external service (Wormald Ltd)

Staff interviews and review of nine personnel files provides evidence of current training in emergency preparedness.

All RNs and senior caregivers are required to maintain comprehensive first aid certificates. Emergency and security situation education is provided to service providers at regular intervals (confirmed by review of nine staff records and interview with manager). Information in relation to emergency and security situations is displayed for staff, residents and visitors. Emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting.

There is no generator but there is emergency lighting, stored torches, gas hobs and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones for use during power outages. Call bells are accessible / within easy reach, and are available in all resident areas (eg, bedrooms, ablution areas, ensuite toilet/showers, dayrooms, dining rooms). The maintenance person completes regular checks of these. Residents interviewed said staff respond to call bells in a timely manner.

Emergency and security systems meet the ARC requirements.

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: All bedrooms and communal areas have good natural light, safe ventilation, and effective heating. Eight residents and three family members interviewed stated the environment is maintained at a safe and comfortable temperature. There is a designated external smoking area. The service meets the ARC requirements.

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:

Document Review: The Restraint Minimisation Policy contains definitions that are congruent with this standard. It states the only restraint authorised for use are bed rails, safety belts, safe holding, harness and pelvic restraint. It designates a restraint co-ordinator, and clearly describes the processes for assessment, consent, review and monitoring and ongoing staff education. The enabler policy states the service allows the voluntary use of bedrails and lap belts. The policy states that assessment is needed, consent is obtained and that the enabler is reviewed six monthly or earlier. The proforma submitted for assessment, consent and review contain appropriate guidelines. The service has appropriate and well described behaviour management policies, flow charts and monitoring records.

There are four residents who use bed rails as enablers, and one of these also requires a lap belt when in wheelchair for correct positioning (review of restraint register, interview with restraint co-ordinator, on site observation and review of three residents' files who are using restraints).

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

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

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 co-ordinator role has clear terms of reference in the position description and the role is designated to an experienced RN. This person is supported by members of the restraint and challenging behaviours group. The group meets monthly to review all residents who have restraint interventions and discuss other behaviours of concern. There are three residents listed in the restraint register as using bed rails as restraints.

Evidence:

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.)

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: PA Low

Evidence:

Any residents with behaviour or conditions that compromise safety or mobility are discussed at the Restraint and Behaviours of Concern group, as confirmed by interview with the restraint coordinator and clinical manager and review of group meeting minutes. The restraint policy details different risk associated with each type of restraint but there is no evidence that the risks associated with an individual resident are taken into account during the assessment process and these are not recorded in the assessment plan or in the care plan.

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: PA Low

Evidence:

The restraint policy details different risk associated with each type of restraint but there is no evidence that the risks associated with an individual resident are taken into account during the assessment process and these are not recorded in the assessment plan or in the care plan.

Finding:

The assessment process does not include identifying risks associated with the individual and/or the type of restraint in use.

Corrective Action:

Ensure the assessment procedure includes consideration and identification of any risk associated with the individual and/or the type of restraint in use.

Timeframe (days): 180 (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:

Review of the care records for the three residents who have bed rails described as restraint, contain evidence that alternatives to bed rails have been tried or considered but rejected for appropriate reasons. The individual assessment and review process and the 6 monthly restraint audit process check that the restraint is only applied as a last resort for safety reasons, and that the decision is made by a suitably qualified and experienced person or group following careful consideration and preparation.

The care records contain adequate information about the reasons for use, what else was tried or could be used as an alternative, when it is to be used and how frequently it is to be monitored and reviewed.

The restraint register contains a chronological account of all restraint and enabler in use, including the residents name, what the intervention is, when it was commenced and when it is reviewed.

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:

All restraint interventions are evaluated at least six monthly by the restraint group and the co-ordinator. These occur in consultation with the resident and their family. This is confirmed by review of residents' records and interview with the restraint co-ordinator, one resident and one relative.

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

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: The restraint co-ordinator writes a narrative summary report each year about restraint activity. The report includes the extent of all restraint use, any changes that have occurred in policy or practice and the extent of staff education. All restraint activity is audited and reviewed six monthly by the manager. These practices met the requirements of this standard.

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: Document Review: There is a comprehensive infection control manual which contains policies on all expected subject topics. The manual is referenced to the Bug Control

manual 2013. There is a designated infection control co-ordinator and evidence of annual review.

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters within the organisation leading to the senior management. The infection control co-ordinator is the clinical nurse manager and they have a job description that has the roles, responsibilities and accountability for infection matters (sighted). The monthly and annual infection report is provided to the owner/operator.

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. The annual review was last conducted in December 2013. The annual review covers quality improvements, policies, procedures, surveillance, staffing, standard precautions and education.

Policy states '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'. There is a policy for staff not to come to work if they are unwell, there is a notice at the front door advising visitors not to have contact with residents if they are unwell or have been exposed to infections, and at times residents may be isolated where possible and practical. The infection control co-ordinator reports that one resident who came back from a family visit where the family had developed gastroenteritis was isolated to their room for 48 hours after their symptoms has ceased. No other residents or staff were infected.

The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control meeting is incorporated into the monthly staff meeting. The infection control co-ordinator tables the monthly infection control report at the staff meeting. The reports and surveillance data are also placed on the staff notice board.

The infection control co-ordinator has the range of skills, expertise, and resources necessary to achieve the requirements of this Standard. The infection control co-ordinator is part of a local and regional infection control network and forums for infection control. The infection control co-ordinator can access expertise and resources through the DHB and external specialist infection control providers to ensure the documented goals for the infection control programme can be maintained. The infection control co-ordinator confirms that the service also has access to external advice through the GP, product supplier, diagnostic service, and DHB and Ministry of Health services as required.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are written policies and procedures for the prevention and control of infections which comply with relevant legislation and current accepted good practice. The service utilises polies and procedures from an infection prevention and control advisory service. The policies and procedures are referenced to current accepted good practice. The service receives newsletters and education through the advisory service to ensure current accepted good practice. Infection prevention and control objectives are set and reviewed annually and the 2014 objectives have been set. All objectives are reported against at infection control meetings and in the annual review report.

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:

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. The infection control co-ordinator and specialist

infection control person's conducts the education. The infection control co-ordinator has attended an infection prevention and control forum twice in 2013, which included education on the management of multi-resistant organisms, outbreak management, developing strategies for prevention and risk management. The infection control co-ordinator demonstrates knowledge of current best practice for infection prevention and control. The infection control co-ordinator managed a project on the review of the cleaning products and gloves in 2013 to ensure best practice is achieved (also refer to criterion 1.2.3.6 and 1.1.8.1).

Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control co-ordinator has conducted informal education with residents regarding influenza vaccination.

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 organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. The surveillance is based on accepted definitions for aged care services. Monthly surveillance is conducted for respiratory, urine, skin and gastroenteritis infections.

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. The monthly surveillance data is collated and analysed by the infection control coordinator. The service has no recorded urine infections for November and December 2013. The infection control coordinator reports that UTIs are low for 2013 and to date in 2014 (with none or one UTI recorded for most months and two UTIs recorded in January and September 2013). The trend analysed for infections records that there is an increase in the number of skin and soft tissue infections. The infection control co-ordinator reports that this is partly related to the changing of the standardised definitions for skin infections. Five skin and soft tissue infections are recorded in September and November 2013, with this decreasing to two recorded infections in December 2013. The frail medical condition of the residents is related to the skin infections (eg, chronic and malignant condition) with no trends identified with the residents or staff related to the increase in skin infections. The infection control co-ordinator is currently conducting a quality improvement project to review the services processes and preventive measures for skin tears and bruising (refer to criteria 1.2.3.6 and at 1.4.1.1).

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>