

Adriel Rest Home Limited

Current Status: 1 April 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

Adriel Rest Home Limited operates in two premises on co-joined sites - Adriel Rest Home and Adriel House. Both provide rest home level dementia care in a semi-rural environment. Currently, Adriel House is newly completed and is being occupied by the more independent residents to allow for an emphasis on activities of daily living in order to maintain the resident's current level of functioning and strength in line with the services 'Spark of Life' philosophy. On the day of audit there were 17 residents in Adriel Rest Home and 8 residents in Adriel House.

The service demonstrates particular strengths in the provision of services in line with current best practice with the implementation of the Spark of Life philosophy, and in the utilisation of InteRai in the planning and development of care.

There are four areas identified as requiring improvement from this audit and these relate to the documentation of informed consent; the documentation of actions taken in response to the monitoring of internal processes; the documentation of monitoring of residents during episodes of restraint; and the updating of infection control policies and procedures.

Audit Summary as at 1 April 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 1 April 2014

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

Organisational Management as at 1 April 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.
---	--	---

Continuum of Service Delivery as at 1 April 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.		All standards applicable to this service fully attained with some standards exceeded.
--	--	---

Safe and Appropriate Environment as at 1 April 2014

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

Restraint Minimisation and Safe Practice as at 1 April 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.
---	--	---

Infection Prevention and Control as at 1 April 2014

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

Audit Results as at 1 April 2014

Consumer Rights

The Code of Health and Disability Services Consumers' Rights is being communicated to residents and their families and is upheld throughout service provision. Cultural, ethnic, religious and spiritual considerations are taken into account and although not currently required, there is a comprehensive Maori plan to guide staff in ensuring the needs of Maori are met.

Residents are supported to maintain their independence, their privacy is respected and family members talk favourably about the high level of care and support provided and the consistently good communication from staff and managers.

Information about the Nationwide Health and Disability Advocacy Services is made available and family members are recognised as advocates for their relatives.

The documented complaints process is easily accessed, responsive, and fair and complies with Right 10 of the Code. There are minimal complaints received by the service.

The care and support provided at the Adriel Rest Home and Adriel House is underpinned by the principles and philosophy of the 'Spark of Life' programme. This evidence-based programme is having a significantly positive impact on the residents in this facility. Ongoing continuous improvement is evident with the implementation of this programme.

An area requiring improvement around the policy, documentation and practices for informed consent and related processes is identified.

Organisational Management

The service has a mission statement, philosophy and set of values. A current strategic business plan with objectives is available. Key documents include organisational policies and procedures, a quality plan, a risk management plan and a Maori plan and a review process is in place to ensure currency.

Quality and risk management systems are established with internal audits, satisfaction surveys, incidents and accident records, infection control, health and safety and issues around service delivery, being discussed at monthly staff meetings and three monthly quality meetings. Incident and accident reports and internal audit results are being analysed and reviewed. The management of corrective actions requires improvement as although shortcomings are being addressed, the

formal documentation of this is not consistently used. Hazard and risk registers are used and reviewed to ensure they reflect the current needs of the service.

Human resources processes are supporting the employment of suitable employees. Practising certificates of staff are current and a copy kept on file by the service. Training is made available to staff with all support workers having completed or currently undergoing a national certificate in aged care. Additional topics are provided at in-service training sessions. All new staff are required to undertake an orientation programme, and records of this are retained.

Staff rosters are seen to meet the needs of the service and there is good registered nurse support as required.

Client records are integrated, identifiable and accurate. The storage of current and archived client files is secure.

Continuum of Service Delivery

Information about the service is accessible via the internet, in a welcome package and in a brochure. Referrals to this service come from a range of sources, however a pre-requisite of entry is an assessment by a Needs Assessment and Service Coordination (NASC) agency that informs a person requires rest home level dementia care.

Continuous improvement is evident in the proficient use of interRAI for assessments, the development of service delivery plans and for evaluation and review processes. Innovative use of the analysis of resulting data is occurring. All stages of service delivery planning are kept up to date and any changes are captured in interim care plans that are implemented between review timeframes.

Residents are kept stimulated by three activities coordinators and a diversional therapist who facilitate group and one-on-one activities that are available seven days a week. Individualised activity plans are in residents' personal files.

Medicines are being managed safely according to policies and procedures that follow legislative requirements and best practice guidelines. Competencies for administration are up to date and monitoring processes are in place.

A menu that has been reviewed by a dietitian guides the preparation of meals and ensures residents consume an adequate nutritional intake. Staff complete safe food handling training and current kitchen practices and monitoring process reflect accepted food safety principles.

Safe and Appropriate Environment

Methods of managing waste and of identifying and managing hazards are well documented and meet requirements. Personal protective equipment is readily available and being used by staff.

The facility has a current building warrant of fitness. Electrical checks and equipment maintenance checks have been undertaken within the past twelve months. The new Adriel House is having external areas landscaped and there is a plan in place to renovate and/or redecorate some interior rooms within the rest home.

There is level access to the both facilities and throughout. Ramps and pathways are in place to facilitate the use of walking aids. Bathroom facilities are adequate. The dining, lounge and kitchen spaces are open plan and comfortable in both homes.

Fire evacuation trials are up to date, security arrangements are in place and call bells are operational. A check of emergency supplies and storage is undertaken during routine checks and the service has adequate supplies to meet the needs of the residents.

Cleaning and laundry procedures and schedules are available and these systems are monitored as part of the internal audit system.

All residents' bedrooms and living areas have windows that are able to be opened for ventilation. Wood fires, gas fires and electrical heaters are available and used in cooler weather. There is a sheltered designated area outside for residents who choose to smoke.

Restraint Minimisation and Safe Practice

Policies and procedures on restraint minimisation are in place and meet the requirements of the Standard. The use of restraint is actively minimised. There are currently two residents requiring restraint at the Adriel Rest Home.

Most aspects of restraint use are adequately documented; however improvement is required in relation to the documentation of monitoring during restraint use.

All staff have undertaken training in restraint and enabler use, as well as managing challenging behaviours, in the last twelve months.

Infection Prevention and Control

The infection prevention and control programme and its associated policies and procedures are discussed and agreed at the initial quality meeting for the year and the 2014 programme has been agreed to by the registered nurse/owner.

Review of the policy documents identify a number of policies and procedures that are not dated and do not reflect current infection control terms and principles. This is an area requiring improvement.

Training related to infection prevention focuses on hand washing, work flow, waste management and the use of personal protective equipment. Staff undergo annual hand washing audits and complete a questionnaire on wider infection control information at orientation and annually thereafter.

Surveillance procedures are detailed in the documents and discussed at quarterly quality meetings. The analysis of surveillance results is undertaken monthly and reported to the staff.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Adriel Rest Home Limited		
Certificate name:	Adriel Rest Home Limited		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Certification Audit		
Premises audited:	Adriel Resthome		
Services audited:	Dementia care		
Dates of audit:	Start date: 1 April 2014	End date: 2 April 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:			25

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	
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	24	Total audit hours off site	12	Total audit hours	36
Number of residents interviewed	2	Number of staff interviewed	12	Number of managers interviewed	2
Number of residents' records reviewed	10	Number of staff records reviewed	9	Total number of managers (headcount)	2
Number of medication records reviewed	11	Total number of staff (headcount)	25	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	

Declaration

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

I confirm that:

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

Dated Thursday, 17 April 2014

Executive Summary of Audit

General Overview

Adriel Rest Home Limited operates in two premises on co-joined sites - Adriel Rest Home and Adriel House. Both provide rest home level dementia care in a semi-rural environment. Currently, Adriel House is newly completed and is being occupied by the more independent residents to allow for an emphasis on activities of daily living in order to maintain the resident's current level of functioning and strength in line with the services 'Spark of Life' philosophy. On the day of audit there were 17 residents in Adriel Rest Home and 8 residents in Adriel House.

The service demonstrates particular strengths in the provision of services in line with current best practice with the implementation of the Spark of Life philosophy, and in the utilisation of InteRai in the planning and development of care.

There are four areas identified as requiring improvement from this audit and these relate to the documentation of informed consent; the documentation of actions taken in response to the monitoring of internal processes; the documentation of monitoring of residents during episodes of restraint; and the updating of infection control policies and procedures.

Outcome 1.1: Consumer Rights

The Code of Health and Disability Services Consumers' Rights is being communicated to residents and their families and is upheld throughout service provision. Cultural, ethnic, religious and spiritual considerations are taken into account and although not currently required, there is a comprehensive Maori plan to guide staff in ensuring the needs of Maori are met.

Residents are supported to maintain their independence, their privacy is respected and family members talk favourably about the high level of care and support provided and the consistently good communication from staff and managers.

Information about the Nationwide Health and Disability Advocacy Services is made available and family members are recognised as advocates for their relatives.

The documented complaints process is easily accessed, responsive, and fair and complies with Right 10 of the Code. There are minimal complaints received by the service.

The care and support provided at the Adriel Rest Home and Adriel House is underpinned by the principles and philosophy of the 'Spark of Life' programme. This evidence-based programme is having a significantly positive impact on the residents in this facility. Ongoing continuous improvement is evident with the implementation of this programme.

An area requiring improvement around the policy, documentation and practices for informed consent and related processes is identified.

Outcome 1.2: Organisational Management

The service has a mission statement, philosophy and set of values. A current strategic business plan with objectives is available. Key documents include

organisational policies and procedures, a quality plan, a risk management plan and a Maori plan and a review process is in place to ensure currency.

Quality and risk management systems are established with internal audits, satisfaction surveys, incidents and accident records, infection control, health and safety and issues around service delivery, being discussed at monthly staff meetings and three monthly quality meetings. Incident and accident reports and internal audit results are being analysed and reviewed. The management of corrective actions requires improvement as although shortcomings are being addressed, the formal documentation of this is not consistently used. Hazard and risk registers are used and reviewed to ensure they reflect the current needs of the service.

Human resources processes are supporting the employment of suitable employees. Practising certificates of staff are current and a copy kept on file by the service. Training is made available to staff with all support workers having completed or currently undergoing a national certificate in aged care. Additional topics are provided at in-service training sessions. All new staff are required to undertake an orientation programme, and records of this are retained.

Staff rosters are seen to meet the needs of the service and there is good registered nurse support as required.

Client records are integrated, identifiable and accurate. The storage of current and archived client files is secure.

Outcome 1.3: Continuum of Service Delivery

Information about the service is accessible via the internet, in a welcome package and in a brochure. Referrals to this service come from a range of sources, however a pre-requisite of entry is an assessment by a Needs Assessment and Service Coordination (NASC) agency that informs a person requires rest home level dementia care.

Continuous improvement is evident in the proficient use of interRAI for assessments, the development of service delivery plans and for evaluation and review processes. Innovative use of the analysis of resulting data is occurring. All stages of service delivery planning are kept up to date and any changes are captured in interim care plans that are implemented between review timeframes.

Residents are kept stimulated by three activities coordinators and a diversional therapist who facilitate group and one-on-one activities that are available seven days a week. Individualised activity plans are in residents' personal files.

Medicines are being managed safely according to policies and procedures that follow legislative requirements and best practice guidelines. Competencies for administration are up to date and monitoring processes are in place.

A menu that has been reviewed by a dietitian guides the preparation of meals and ensures residents consume an adequate nutritional intake. Staff complete safe food handling training and current kitchen practices and monitoring process reflect accepted food safety principles.

Outcome 1.4: Safe and Appropriate Environment

Methods of managing waste and of identifying and managing hazards are well documented and meet requirements. Personal protective equipment is readily available and being used by staff.

The facility has a current building warrant of fitness. Electrical checks and equipment maintenance checks have been undertaken within the past twelve months. The new Adriel House is having external areas landscaped and there is a plan in place to renovate and/or redecorate some interior rooms within the rest home.

There is level access to the both facilities and throughout. Ramps and pathways are in place to facilitate the use of walking aids. Bathroom facilities are adequate. The dining, lounge and kitchen spaces are open plan and comfortable in both homes.

Fire evacuation trials are up to date, security arrangements are in place and call bells are operational. A check of emergency supplies and storage is undertaken during routine checks and the service has adequate supplies to meet the needs of the residents.

Cleaning and laundry procedures and schedules are available and these systems are monitored as part of the internal audit system.

All residents' bedrooms and living areas have windows that are able to be opened for ventilation. Wood fires, gas fires and electrical heaters are available and used in cooler weather. There is a sheltered designated area outside for residents who choose to smoke.

Outcome 2: Restraint Minimisation and Safe Practice

Policies and procedures on restraint minimisation are in place and meet the requirements of the Standard. The use of restraint is actively minimised. There are currently two residents requiring restraint at the Adriel Rest Home.

Most aspects of restraint use are adequately documented; however improvement is required in relation to the documentation of monitoring during restraint use.

All staff have undertaken training in restraint and enabler use, as well as managing challenging behaviours, in the last twelve months.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme and its associated policies and procedures are discussed and agreed at the initial quality meeting for the year and the 2014 programme has been agreed to by the registered nurse/owner.

Review of the policy documents identify a number of policies and procedures that are not dated and do not reflect current infection control terms and principles. This is an area requiring improvement.

Training related to infection prevention focuses on hand washing, work flow, waste management and the use of personal protective equipment. Staff undergo annual hand washing audits and complete a questionnaire on wider infection control information at orientation and annually thereafter.

Surveillance procedures are detailed in the documents and discussed at quarterly quality meetings. The analysis of surveillance results is undertaken monthly and reported to the staff.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	2	44	0	4	0	0	0
Criteria	2	93	0	3	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	2	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Moderate	Documentation for informed consent, enduring power of attorney and forms relating to end of life wishes are not being completed according to legislative requirements and best practise. Practices around informed consent and related processes are not consistent with documented policies and not all policies meet legislative requirements.	Policies and procedures on informed consent processes require review; practises around informed consent and related processes are to be consistent with organisational policies and informed choices about the care and support provided, and related forms such as for enduring power of attorneys, are to be documented according to legislative requirements and accepted best practice.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The development of a corrective action plan is not consistently demonstrated to determine that shortfalls identified through the monitoring processes, are being addressed.	Ensure corrective action plans are consistently documented to determine that identified shortfalls are being addressed.	180
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 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	PA Low	Monitoring of the restraint is included in care planning but is not clearly documented in the resident's progress notes that this has occurred.	Ensure observations and monitoring of residents is documented during the use of restraint.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				
HDS(IPC)S.2008	Standard 3.3: Policies and procedures	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.	PA Low			
HDS(IPC)S.2008	Criterion 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.	PA Low	The programme and policies sighted are not consistently dated with current review dates and current terms used to describe infection control principles that reflect current best practice.	Ensure policies and procedures are updated regularly and reflect current best practice	180

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 'Spark of Life' approach/programme that is being implemented at Adriel Rest Home is a research based person-centred programme specifically designed for enhancing the lives of people with dementia. The manager is a Master Practitioner in it and staff are trained in its principles. There are anecdotal reports of the benefits of the programme from the managers, staff and family members that are supported by documented records. Documented and reported benefits include people

Code	Name	Description	Attainment	Finding
				being happier, able to express themselves better, able to do more for themselves and to participate in activities not usually embarked upon. Its value is being measured through quality improvement system data for incident/accidents, staff and family surveys and in resident evaluation and reviews of their service delivery plans and activities plans. The current review systems are part of a formal evaluation that the managers have commenced to enable the service to become a national 'centre of excellence' in the use of the 'Spark of Life'.
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	CI	
HDS(C)S.2008	Criterion 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.	CI	The interRAI computer tool/programme is being used in a competent manner that demonstrates continuous improvement. On admission, interRAI is being consistently used for all residents for the completion of individualised assessments, the development of comprehensive service delivery plans and for the six monthly evaluations and reviews. Its use is ensuring all residents' needs are being met safely and holistically. Information and data from using interRAI is being used in innovative ways, such as for measuring acuity that justifies changes in staffing levels when necessary, to identify staff training needs and to compare areas where progress has been less than expected. This latter use is not just occurring at the individual level, but also to find and address areas for improvement service-wide. In addition, the framework of the interRAI programme is being used for the development of residents' activities plans

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:

A simplified version of the Code of Health and Disability Services Consumers' Rights (the Code) is included in the copy of the welcome pack for new residents/family/whanau provided for stage one audit. There is policy document that states a copy of the full brochure on consumer rights is included in the welcome pack and that posters displaying the rights are displayed at the front entrance.

During the audit visit, service providers, otherwise known as support partners, demonstrate patience, respect and understanding as they work with the residents. Five family members interviewed inform that they believe the residents are having their rights recognised and state that they have never seen any example of their rights not being acknowledged. Two staff/support partners inform that they receive training from the advocacy support services on consumer rights and that pamphlets about rights are available

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:

The nurse manager explains how the Code of Rights is discussed with family members and with residents when they are first admitted to the facility. A copy of the Code is provided with the welcome package prior to admission and an example of this package with the brochure inside is sighted. Three relatives spoken with confirm that they were provided with information about the Code by the owner and/or the nurse manager and say they were also told about the Nationwide Health and Disability Advocacy Service. Posters on the Code of Rights that include information on the Health and Disability Advocacy Service are on display at the front entrance of the rest home. A summarised version of the Code of Rights is viewed on a noticeboard.

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

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

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

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

Attainment and Risk: FA

Evidence:

A policy and procedure on abuse and neglect includes definitions, descriptions of the different types of abuse, avoidance of abuse, and monitoring processes. It notes that it is mandatory for all staff to report any suspicious, actual or potential abuse or neglect of a resident. The management strategies for support partners are outlined in a policy on sexuality and intimacy, which endeavours to ensure all sexual activity, is appropriate and any relationship is consensual. A spirituality policy provides definitions, gives an overview about what spirituality is and describes how Adriel Rest Home will accommodate spiritual requirements. There is a policy and procedure on physical privacy and how this will be achieved, including when a resident has a visitor or a telephone call.

A key message that was conveyed throughout interviews with six family members of residents is that all of the staff treat the residents with great respect and that they care about the people they look after. Staff are viewed respecting the privacy of the residents and their belongings by knocking on doors and calling out before entering, by returning items to your rightful owner when uplifted by another resident and ensuring toilets and bathroom doors are closed when a resident enters. The nurse manager provides a range of examples of how the needs values and beliefs of different residents are addressed. Some of these examples are evident throughout the care plans that were reviewed, in particular in the activity plans. Residents who want to attend the monthly church service are assisted to do so, those who wish to attend local community events are supported to do so if they are physically able and staff are observed reading to residents, walking alongside them outside, massaging hands and assisting them to peel quinces on a one-on-one basis.

There is no evidence of any form of abuse or neglect and the family members state that they have never seen anything untoward happen for any resident. Individualised risk management is a component of each of the seven resident's care plans in which this is checked.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The Maori Health Plan acknowledges that residents of Maori descent may have special cultural needs. The plan notes the way in which cultural and/or spiritual perspectives will be determined, that bi-lingual information sources will be used when relevant, provides details about the local iwi and Maori representatives and how they may be accessed to ensure cultural needs are met. According to the policy, staff are to participate in education relating to the Maori perspective of health, Maori values, beliefs and cultural practices. A separate policy and procedure attached to the Maori Health Plan is on death/tangihanga of a Maori resident.</p> <p>A person of Maori descent has reportedly not demonstrated any desire to have any specific cultural needs met. As there are no family involved and there is limited information available about the history of this person, the nurse manager informs that staff respect her choice not to accept the offers of Maori culture specific options that have been provided. The nurse manager confirms the links that they have with local iwi and tangata whenua should this be required.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Ways in which culturally safe care will be provided are described in a policy on cultural values and sensitivity, including religious, social and spiritual needs. This document informs that there will be no discrimination or prejudice because of race, sex, creed, gender, religious beliefs or discriminatory factors, that family will be consulted on requirements, food preferences will be identified, the care plan will reflect these needs, interpreters will be accessed as required and respect of all staff for cultural beliefs will be enhanced through in-service education.

Efforts are relayed about ways in which the staff at Adriel have investigated the cultural needs of a Maori person. A resident from a European country was given additional assistance to enable her to have items of cultural importance to her brought into the facility for display in her room; these were sighted. During interview, this person is able to confirm that her cultural needs are met and says that staff talk with her about life in her homeland.

Residents are assisted to attend a monthly ecumenical service if they choose and if family members have indicated this is likely to benefit their relative. Cultural needs are identified and interventions planned as identified in the care plans reviewed.

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:

Support partners sign a code of conduct when they commence employment at Adriel Rest Home and a copy of this is retained in their staff file. Six of six family members are confident that there is no form of discrimination, or other exploitation occurring within this facility. Incident forms are being completed for any adverse event and each of these is investigated by the nurse manager and/or the owner. The nurse manager informs that there have been no reports of any form of discrimination or harassment by staff. When a resident demonstrates behaviour that may be considered as inappropriate to another resident, the staff are trained to redirect the person and ensure all such incidences are documented.

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:

The service is actively using the research based 'Spark of Life' approach that has been developed to enhance the lives of people with dementia. This is operating at a level of continuous improvement as the introductory use of programme was proving so successful that the manager became a Master practitioner of it and all staff are now trained in its principles. Family members interviewed are positive about the benefits the programme is bringing to relatives and staff are feeding back that they have many more options for managing residents.

Quality improvement data are showing a downward trend in incidents/accident reports that coincide with the training of staff in its principles. Separate family and staff surveys provide positive information about the programme, and reviews in personal files are showing improvements regarding behaviour, activities and increased independence with personal cares. There are reports that residents are appearing more energised and that their eyes light up when they participate in certain aspects of the programme such as the Sunshine Club and the Men's Club.

In addition to the 'Spark of Life' being identified separately in quality system and resident review processes, the managers have commenced a formal evaluation of the programme that will contribute to their goal of becoming a 'Spark of Life' centre of excellence in New Zealand.

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 owner/registered nurse and the nurse manager both express a commitment to using evidence based practices to ensure the services delivered are the best possible. In addition to the advanced use of the InterRAI programme there are intentions in place and progress underway towards Adriel becoming a Centre of Excellence for the delivery of services for people with dementia. This relates to the 'Spark of Life' programme, which is a person-centred approach that is described as 'a gentle, practical and celebratory approach to human relationships and communication, dedicated to uplifting the spirit of people with dementia'. The manner in which this approach is being used involves more than the usual expectations when delivering services for people with dementia and is identified as an area of continuous improvement.

This programme was introduced into the Adriel rest home environment several years ago and is based on a practical approach for person centred care that focuses on people maintaining their independence as long as possible. It is a research based approach that is gaining increasing recognition and is found to be especially effective for people with dementia. The owner of the facility has completed her training as a Master Practitioner in the approach. All staff are trained in using the 'Spark of Life' approach and during conversations with the nurse manager and two support partners there is a level of excitement about its benefits for the residents.

Three family members inform of identifiable changes they have seen in their relative. Examples provided include that sentences are finished during the Sunshine club, decisions are now made when options are provided and that has not happened for years and that their relatives eyes now often shine to the point that they can tell they are contented and even excited.

Staff and the managers relate examples of slow but specific changes that are occurring for individuals, based on initial observations and assessment information obtained on admission. These are documented in the care plan reviews in resident's files and although changes are especially evident in the activities plan reviews there are also examples of people becoming more interested in their environment and in doing more for themselves, including feeding themselves and cleaning their teeth for example.

The owner/registered nurse and nurse manager independently report that residents' eyes light up when different aspects of 'Spark of Life' are used and that aspects of the programme such as the clubs mean people demonstrate energy not usually apparent. They also report that there is no longer a need for behaviour management recording charts as whatever behaviour a resident may display is accepted for what it is, considered to be an unmet need and is managed accordingly. Staff inform that the 'Spark of Life' approach has given them more options of ways to better manage residents with dementia and has given them more confidence as they see results. A staff survey is also a means of positive feedback to the managers about the value of 'Spark of Life'.

The nurse manager has included aspects of the programme when considering quality improvement data. An example provided is that the incident/accident reporting data, which is sighted, shows a steady and consistent downward trend in all three areas that relate to residents. The identified common element is that the timeframe coincides

with the staff training on use of the approach in all aspects of resident care. 'Spark of Life' was included in the latest family member survey with positive and specific examples included in the feedback. In addition to including 'Spark of Life' in quality system and resident reviews, the managers have commenced a formal evaluation process for the programme as a component of their goal of Adriel becoming recognised as a 'Spark of Life' centre of excellence, which is expected to be the second in New Zealand.

Finding:

The 'Spark of Life' approach/programme that is being implemented at Adriel Rest Home is a research based person-centred programme specifically designed for enhancing the lives of people with dementia. The manager is a Master Practitioner in it and staff are trained in its principles. There are anecdotal reports of the benefits of the programme from the managers, staff and family members that are supported by documented records. Documented and reported benefits include people being happier, able to express themselves better, able to do more for themselves and to participate in activities not usually embarked upon. Its value is being measured through quality improvement system data for incident/accidents, staff and family surveys and in resident evaluation and reviews of their service delivery plans and activities plans. The current review systems are part of a formal evaluation that the managers have commenced to enable the service to become a national 'centre of excellence' in the use of the 'Spark of Life'.

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:

An open disclosure policy exists to guide staff.

Open disclosure is noted to occur in the follow-up of incidents/accidents where this is appropriate. The Nurse Manager (NM) is able to discuss the process of investigation and follow-up of incidents, accidents and medication errors and any communication with the resident's family. Progress notes in residents' files sighted include information about contact with family members.

A communication record sheet has been placed in each of the resident's files (sighted). This is completed in most instances when family members are contacted, and also shows evidence of open communication processes when an incident occurs (sighted). Four of four family members who are asked about communication with the management and staff are quick to praise the staff for the effective communication processes in place. Two family members volunteer unprompted about how good the staff are at contacting them when even the slightest thing that is out of the ordinary occurs with their relative.

Review of family satisfaction surveys from 2013 indicates relatives believe they are well informed about any updates or incidents involving their family member.

The NM notes that any need for the interpreter service would be identified at the initial assessment. The Interpreter policy provides guidance to staff, as well as telephone numbers to contact interpreters as required. There is no evidence that any of the current residents require interpreter services and the nurse manager informs that to her

knowledge there has never been a need to contact the DHB, or similar agency to request interpreter services.

All ARC requirements are met.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

An informed consent policy and procedure document describes the purpose, rationale and circumstances through which informed consent will be obtained. It notes what Adriel Rest Home will require informed consent for, states what an advance directive is and the circumstances in which instructions from an advance directive will be used. Informed consent is obtained for receiving and recording information, for training, for outings, for photography, for transfer and regarding health information. A blank copy of the informed consent form sighted during stage one audit is consistent with the policy.

The nurse manager describes the information that is obtained from friends and family when a new resident is admitted. Residents are involved in this process as far as they can manage, although it is primarily undertaken with the person's EPOA. Staff are observed to be giving residents choices about what they want to do and where they want to go. It is noted that two choices are given at a time, which the owner of Adriel informs is consistent with the 'Spark of Life' philosophy.

At audit, the nine client files reviewed include a consent form signed by the resident's enduring power of attorney (EPOA). Neither the informed consent form, nor the EPOA forms are being completed according to legislative requirements and best practice. Although there are policies and procedures on Advance Directives, these have been superseded by a 'Guidelines as to End of Life Wishes' form in residents' files, which is not being completed and signed by the GP as per the described requirements on the form. An area for improvement is around the need for a review of informed consent processes and the use of the 'Guidelines as to End of Life Wishes' form.

There are no residents in this service who have an Advance Directive in place; therefore criterion 1.1.10.7 is not applicable.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate
Evidence: Client files include a consent form signed by the resident's enduring power of attorney (EPOA). This form is also signed by the registered nurse, although in one file a senior care giver has signed it. There is no guideline about what the registered nurse or the senior caregiver is signing and there is uncertainty as to whether it is in the role of witness, or confirming they have provided the necessary information. An EPOA form has been completed by one person with the name of a different person as being the EPOA elsewhere and there is a 'Guidelines as to End of Life Wishes' form in residents' files that is not being completed and signed by the GP as per the requirements on the form. Advance directives are included in the policy documentation on informed consent, although these are no longer in use.
Finding: Documentation for informed consent, enduring power of attorney and forms relating to end of life wishes are not being completed according to legislative requirements and best practise. Practices around informed consent and related processes are not consistent with documented policies and not all policies meet legislative requirements.
Corrective Action: Policies and procedures on informed consent processes require review; practises around informed consent and related processes are to be consistent with organisational policies and informed choices about the care and support provided, and related forms such as for enduring power of attorneys, are to be documented according to legislative requirements and accepted best practice.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA
Evidence: The complaints policy informs about the purpose of the advocacy service and how the service may be contacted. It notes the role and contact details of the Health and Disability Commissioner (HDC) for an appeal process following a complaint. Contact details of the HDC Advocacy Service are also in the welcome pack sighted at stage one audit. As all residents have a level of dementia they are dependent on the staff and/or relatives to advocate on their behalf. It is observed on two occasions during the audit that when a resident did not follow through on the requests of a support partner that another support partner went in later to get co-operation from the resident. During conversation with the nurse manager and to support partners it is evident that support partners are taught to be open with family members and work alongside them especially when a resident is difficult to manage. Family members spoken with are familiar with the Independent Advocacy Service but all believe that the staff or managers would listen to, and address, any concern(s). They confirm they are given information about the advocacy service when their relative is admitted.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Visitors are welcome and on the day of audit they are observed coming and going for varying lengths of time. There is a well-used visitors' book at the front entrance. Six of six family members of five different residents confirm they can come and go as they please, are always acknowledged by staff and are provided with brief updates about their relative. A resident speaks about visits from an old neighbour.</p> <p>The community has close links with Adriel Rest Home. Articles in the local newspaper have reportedly prompted telephone calls and visits with people volunteering their time and skills such as crafts, music and singing. This includes visits from schoolchildren. The residents are taken one on one or in small group, for walks, visits to local cafes, the local show, the market and exhibitions as time permits and staff numbers allow.</p>

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The welcome pack for new residents/family/whanau includes a section on the complaints procedure and notes the right for a person to make a complaint and that Adriel Rest Home encourages feedback. It notes complaints are followed up within 5 working days and that a complaints log is held by the service. A copy of the organisational complaints policy is sighted and describes the procedure to be used for this service. The timeframes and accountability processes meet the requirements of the Code. The advocacy service, the appeal process, other complaint processes and actions to be taken on receipt of a complaint are all described in the policy. Blank forms for complaint follow-up, an on-going log of concern and a log of complaints are sighted.</p> <p>The service receives few complaints. The owner/registered nurse (RN) is responsible for the monitoring and response to complaints received. She reports documenting both written and verbal concerns or complaints in the log (sighted). Review of three complaints from the last 12 months, demonstrates the documented process is followed.</p>

Staff interviewed are able to describe the complaint process and know where complaint forms are publicly available.

ARC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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:

The vision of Adriel Rest Home is to be recognised as an innovative leader in specialised dementia care in New Zealand. Providing unconditional love and care for those with memory loss, in a relaxed, caring, friendly, country environment by respecting the whole person is the mission statement for the service. Its values, culture and philosophy endorse the vision and mission statement in relation to the atmosphere and physical environment, the residents, family/whanau, outside contacts, staff, care of the residents and the Spark of Life programme. This vision is described in the information booklet provided to potential new residents and their families and is explained on the Eldernet website.

An organisation chart details the responsibilities of the owner, the management advisors, the registered nurse/manager, personal assistants, an enrolled nurse and a variety of other staff including kitchen aides, support partners, diversional therapist, gardener/maintenance person, infection control officer and health and safety coordinator. Staff interviewed are able to describe the reporting lines.

The business plan for 2014 (sighted) lists points that are to be the key foci for the vision to be recognised. Other details in the plan refer to financial planning; professional and community relationships; staff recruitment, development, training and retention and quality improvement. Ten goals in the strategic plan relate to family/whanau participation, building improvements, community participation, strategic action plans, the workforce, gaining excellence in the Spark of Life, staff development and training, information technology, quality improvement and occupancy of the new home.

The Nurse Manager (NM) has been in the role for a year. She has four years previous experience as a registered nurse (RN) in the facility before gaining 16 months experience introducing interRAI to the sector, returning in March 2013. Additionally she has a post graduate diploma in cognitive behaviour therapy and has completed the Executive Leadership and Management Programme established by the Ministry of Health (MOH).

All ARC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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 RN/owner provides additional RN support and undertakes the role of manager in the absence of the NM. She also provides on call support to the staff. These roles are noted to be reflected in her job description and this is known to staff. All ARC requirements are met

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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: PA Low

Evidence:

At stage one audit, an overview of the quality management manual is sighted and refers to policies and procedures that cover nursing, staff, fire and emergency and health and safety, food services, laundry and cleaning services, administration, maintenance and gardening, infection control and audits. There are objectives for the quality management system that state the system will be maintained and monitored, that a policy of quality improvement is actively encouraged and a system approach to this will be used. The quality plan outlines the organisational/owner responsibilities, the management responsibilities and staff responsibilities around the quality management system. There is a quality team in place who meet quarterly. The membership comprises of the NM, the owner/RN, the enrolled nurse (EN), two support workers, one kitchen staff member and an activities assistant, and is appropriate to the service.

Monitoring and measurement processes of the effectiveness of the system and of policies and procedures are outlined and include ways in which corrective actions will be initiated. A survey/audit policy includes an internal audit schedule (sighted). Review of the audits undertaken, the set agenda and minutes of quarterly quality team meetings verify key components of the quality system are monitored and reviewed to ensure they reflect best practice. External reviews are noted to be undertaken for accounting, fire safety and equipment. Corrective actions are seen to be undertaken in response to issues or shortfalls identified, however corrective action plans are not consistently documented to ensure the actions are completed and this is identified as an area requiring improvement.

Monthly staff meetings are held and quality issues are addressed at this time. This is evident in the meeting minutes sighted (previous four to October 2013). Topics discussed and reports provided include family satisfaction survey results, an analysis of the 2013 accidents and incidents, infection control summary, results of a range of internal audits, staffing issues and service delivery updates. Additionally, the NM and owner have introduced a monthly staff forum following the results of a staff satisfaction survey undertaken mid 2013 where staff identified difficulty in accessing the NM to help resolve any frustrations in the day to day service delivery such as tasks not being completed appropriately. Terms of reference were established to provide guidance around expectations and format of the meetings and the meeting is chaired by the nurse manager. Staff determine any agenda items for discussion and the intention is for the forum to facilitate the staff finding solutions to address any frustrations. Staff interviewed report this has been a very valuable process and has generated greater team work and has empowered them to find ways to manage and resolve any minor issues within the team.

A documented risk philosophy is sighted. Risk is defined in a documented policy that guides the identification and prioritisation of actual and potential risks within Adriel rest home and house. There is a risk register in place (updated Jan 2014) that includes external, internal and operational risks at the home. A risk scoring formula is used. This list is comprehensive and reviews of each of these are occurring as specified, such as through monitoring processes, staff appraisals or internal audits. For example, occupancy has been added and is identified as a high risk whilst the new Adriel House is being filled – the Eldernet website has been updated and there have been a number of articles in the local paper describing the philosophy of the home. Strategies are discussed at the quality meetings and the risk register is reviewed as per the set agenda.

A health and safety policy defines key words and outlines responsibilities and monitoring processes including hazard and health and safety audits, daily recordings of incidents and monthly health and safety reports at staff meetings. Other associated policies around hazard identification and training and supervision for example are sighted. The hazard register for Adriel Rest Home Ltd is sighted and is noted to have been last reviewed in February 2014.

Policies and procedures as required under section D5.4 (a) to (t) of the ARRC agreement are all sighted. All other requirements of the ARC agreement are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Monitoring forms sighted, such as incident and accident forms and internal audit forms are noted to have an area to document findings and identify shortfalls. These are different for all the various forms sighted. Where significant shortfalls exist or there are systems or processes that need to be reviewed and planned, a corrective action log is used to record this and is seen to identify timeframes and responsibilities to address this (sighted). These are noted to be signed off on the log as they are addressed and completed. The inconsistency occurs where there is a one off event or the matter is easily rectified. The documentation of the action required and the responsibility attributed to ensure this occurs, is not consistently completed.
Finding: The development of a corrective action plan is not consistently demonstrated to determine that shortfalls identified through the monitoring processes, are being addressed.

Corrective Action:

Ensure corrective action plans are consistently documented to determine that identified shortfalls are being addressed.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policy documentation on incident and accident reporting, recording and investigation describe the nature of incidents/accidents to be reported and include the related reporting procedures. A policy on open disclosure includes key principles and procedures around it.

The incident reporting process is well established and meets contractual requirements. The NM and owner/RN are able to describe the process for the tracking and investigation of adverse events and the processes for informing family members.

Three forms are used: Medication error; Resident accident/injury; and staff incident/injury. Incidents are investigated to determine whether there are any actions required to mitigate further risk to any identified party, and follow-up is undertaken to ensure this occurs. The documentation of this corrective action is inconsistent and has been

identified as an area requiring improvement (refer CAR 1.2.3.8)

Collation and analysis is occurring to ensure any trends are identified, changes in practice or shortfalls in service delivery or equipment requirements are determined and addressed.

There has been a noticeable decrease in incidents involving resident behaviour since 2011 when the 'Spark of Life' philosophy was introduced to the service. Incidents involving residents' behaviour are noted to have been 10 – 20 per year in 2011 and are now one to seven in the last three quarters of 2013.

All contractual requirements are met

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The Human Resources Manual (last updated August 2013) provides guidance to service providers and includes recruitment, position descriptions, information pack for new staff, orientation and training information, the appraisal policy, competency and education evaluation.

Registered and enrolled nurses all hold current annual practising certificates and records are kept on file. Position descriptions are in place, up to date and describe roles, responsibilities and levels of accountability for all current staff.

Performance appraisals are scheduled on an annual plan. Review of nine staff files indicate all scheduled and due appraisals have been completed. The appraisals for both RNs are noted to be undertaken against the Nursing Council of NZ scope of practice for registered nurses.

Appointment of new staff reflect policy documents and good recruitment practices. Police vetting is consistently undertaken and the documentation of referee checks is seen to be implemented in the files of staff appointed since 2013.

New support workers are required to undertake Aged Care Education (ACE) training following appointment, if they have not already completed their training. A record of this is maintained and all staff meet this requirement. In addition, all but three support workers have also completed the required dementia unit standards. A plan is in place to support their completion of this.

A training schedule exists to record staff education and includes an annual plan of competency updates for medication, first aid and fire training, as well as those priorities of the service. Dates for scheduled training are included in documents sighted and a record of training is seen to be kept in all nine staff files sighted.

All contractual requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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: <p>Rosters are sighted. These are currently completed two weeks in advance whilst the new facility is being occupied and new staff employed to staff this. Otherwise, rosters are normally completed monthly.</p> <p>There is a RN on call 24 hours a day and seven days a week (24/7). The owner/RN undertakes this unless stated otherwise in the communication book (sighted).</p> <p>RN/NM Mon – Friday 8-4pm RN/owner Mon – Fri 9 – 5pm on call w/e and after hours</p> <p>EN Mon/Wed/Fri 9 -3 plus every second weekend (sat/sun) – takes workload in the weekend shifts, otherwise she supports care workers with clinical skills and oversight There is a system to identify staff with current first aid certificate to meet rostering requirements. (two staff are due to undertake the first aid refresher of nine staff files reviewed)</p> <p>The current roster is as follows and staffing levels documented are across seven days per week:</p> <p>Adriel RH (17 residents) AM: 3 support workers (currently one support worker undertakes 2 hours cleaning during this time Mon – Fri) 1 kitchen staff member</p> <p>PM:</p>

2 support workers
1 Kitchen/support worker (4.30 – 9 pm) (supports Adriel House staff member as required)

Night:
1 support worker
1 kitchen staff (supports Adriel House staff member as required)

Activities assistants: 6 hrs/day Mon – Fri, 5hrs Sat/Sun

Adriel House: (8 residents)

AM:
2 support workers (includes 1 FTE activities assistant to enable an activities focus for the more independent residents of Adriel House)

PM:
1 support worker

Night:
1 support worker

Activities assistants: 8 hours/day 7 days/week - this person is included as a support worker, not additional to.(Mon – Sun)

Support workers interviewed report the service is well staffed and they feel well supported by senior staff and RNs.

All ARC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

An electronic record of basic personal details for each resident is obtained at the time of their admission. This is followed up with a full assessment and development of the care plan using the interRAI programme, which is completed within 10 to 20 days of admission. Progress notes are written on each shift for every resident.

All personal client files are stored in the staff room that is locked using a key pad lock. Staff files are stored in a locked drawer in the manager's office that is also locked by a key pad lock. Archived client records are in file boxes on shelves in the staff room and are easily accessible. Neither area is publicly accessible.

All records are legible, either in typed format, or in handwriting. All entries are legible and include the designation of the scribe. There is a register of staff signatures and the names of key professionals such as pharmacists and doctors involved in the care and support of the residents.

Residents' records are fully integrated with all medical, clinical and progress notes for example all in one file. Only medicine charts are kept separate, which facilitates the safe administration of medicines while they are current. Once completed they are archived in the person's archive file.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Entry criteria into Adriel is described in promotional material and in policy documentation. A welcome package that includes information about the service is available for residents, family/whanau, and members of the local community such as the local GP practise and district nurse. The nurse manager informs that most referrals come from the local GP practice and NASC agencies.

Potential residents require a diagnosis of Alzheimer's, or other form of dementia, and need to have been assessed by a needs assessment and services coordination (NASC) agency as requiring dementia level care. All nine residents' files reviewed include documentation from a NASC and show the documentation is being completed in a timely manner.

The nurse manager informs that a short-term care plan is developed on the day of admission and a short interview is undertaken with relatives. She notes that discussion about the care plan and the signing of key documentation by an EPOA is withheld until a later date as this can be a difficult time for all concerned. An appointment is made within seven to ten days for this to occur and this is evident on the signing of informed consent forms and residents' agreement documentation, for example. A long-term care plan using interRAI is completed within three weeks. These nominated timeframes are evident in the personal files viewed.

The requirements of the Aged Related Residential Care (ARRC) agreement are being met.

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

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

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

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:
<p>The nurse manager informs that it is not usual to need to decline entry into the service and she is unable to recall any such instance. She notes that all referrers are aware of the level of care provided at Adriel and that it is a dementia care service.</p> <p>There have been delays for some residents in obtaining permanent residency, however short term respite care has been offered for these people until a bed becomes available. This is not currently a problem as the new on-site facility that has been opened within the past three weeks has a number of empty beds. Two of the six family members interviewed note that their family member had previously received respite care and one expresses relief that their family member has been receiving ongoing care since a deterioration occurred while in respite care.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>The use of the interRAI programme and the ‘Spark of Life’ approach is contributing to ensuring that residents are receiving competent and appropriate services, as per their assessed needs. The registered nurse manager is responsible for all residents’ assessments and reviews, although the owner/registered nurse, who is also a registered nurse, may assist with this at times. As noted in standard 1.2.7, support partners are encouraged and supported to attend ongoing training beyond core requirements. Activities coordinators are rostered over seven days of the week throughout the day and complement the work of support partners who will also assist with activities as time permits. This is observed to be occurring on the days of audit when a support partner takes time to read to a resident who is unsettled and another takes a person for a walk when he becomes restless. Other observations of staff working as a team and assisting one another as required are at meal times; when the nurse manager steps in and guides a person to the toilet on her way past and when a support partner leaves bed-making to assist another person in the washroom. Staff interviewed confirm that the nurse manager and the owner both provide good leadership with the nurse manager being the primary manager at the service delivery level.</p> <p>Tracer methodology is used to demonstrate how individual needs are considered, how assessment and review processes are promoting the way in which services are delivered and how family involvement is encouraged. It also confirms the value of the use of interRAI and of ‘Spark of Life’ approaches, which are identified as areas of continuous improvement. The manager informs that families were offered the opportunity for current residents to move across from the rest home to the new facility of Adriel House when it opened three weeks prior to the audit.</p> <p>Tracer: XXXXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p>

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

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

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

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

Attainment and Risk: FA

Evidence:

The nurse manager states that information used for assessment purposes is gathered from initial referrals, needs assessment documentation, GP feedback, family members and staff observations. Assessment tools for continence, falls risk and skin integrity for example may also be used and examples of these are sighted in residents' files.

The information is fed into the interRAI computer programme, from which assessment comments and an assessment summary are developed. These are filed in nine of the nine residents' records sighted. A tenth file that was checked briefly, rather than being fully reviewed, does not have an interRAI assessment as this person has been admitted for respite care.

The interRAI system helps to identify the main needs and goals of a resident and these are also printed off and filed in residents' files to ensure they are accessible for all staff including visiting professionals such as the GP.

An activities coordinator informs that a personal history of information collected from friends and family members is written up and used to develop a personalised activities plan. The completed personal history documents are sighted in the personal files viewed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: CI

Evidence:

The interRAI computer tool/programme is being used in a competent manner that demonstrates continuous improvement. On admission, interRAI is being consistently used for all residents for the completion of individualised assessments, the development of comprehensive service delivery plans and for the six monthly evaluations and reviews to ensure all residents' needs are being met safely and holistically.

The nurse manager is using the evaluation report data in a constructive manner as it is enabling her to identify the degree of change occurring for each person in a measurable way and enables easy identification of new issues arising. There is evidence that the new issues identified through the use of interRAI are being integrated into the service delivery plans. Trends are being identified and is helping the owner and nurse managers to identify staff training needs when there is a service wide pattern evident in the data extracted. Ideas from the 'Spark of Life' programme are being implemented as a means of addressing unresolved problems, or problems that have an increased rating of complexity.

The framework of the interRAI programme is now being used for the development of activities plan goals and review systems. Information and data from using interRAI is being used to measure acuity at individual and service wide level and is enabling a more accurate assessment and justification of staffing levels and any changes required.

Staff interviewed are comfortable with the interRAI based care plans. Both staff spoken with have worked at Adriel for a long time and inform they find the interRAI documentation easy to follow and helps them to know what they need to do for a person, especially if someone is new, or their needs are changing.

Use of interRAI as a framework for activity goal planning and interventions is facilitating service integration as is information from the GP and other clinicians, such as the psychiatric services for the elderly, the podiatrist and diabetes clinic advisers. Documentation in the residents' files sighted show the information from other professionals such as those noted is used to assist with the assessment, care plan and review processes.

The requirements of the ARC agreement around service delivery planning are being 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: CI

Evidence:

The competent and innovative use of the interRAI computer tool/programme, used to develop residents' service delivery plans, is a second area which shows evidence of continuous improvement. interRAI is being used effectively for individualised assessments and the development of care plans that are resident focused, integrated and promote continuity of service delivery, safe and holistic care and support. These documents are easy to follow, relevant to all staff and pertinent for each individual resident. All assessment information, summaries, care plans and reviews are printed off and filed in residents' personal files.

Eight of the nine files reviewed have evidence of a completed interRAI assessment and a full care plan with the ninth person having arrived less than three weeks ago and

the plan is as yet only partially completed. Seven of the nine have one or more completed evaluations on file. The remaining two have not yet been in the service for six months. Assessment summaries are being completed within three weeks of each resident's admission. interRAI is also being used to undertake residents' evaluations and those on files sighted all accurately relate to the assessments and the goals. They are being consistently completed every six months.

Adriel was part of a pilot programme for the interRAI programme and now has sufficient information and data to compare the trends from assessments and evaluations of individuals and across the service. The nurse manager is using the evaluation report data in a constructive manner as it is enabling her to identify the degree of change occurring for each person in a measurable way and enables easy identification of new issues arising. There is evidence that the new issues identified through the use of InterRAI are being integrated into the service delivery plans, whether or not they have already been identified by staff and an interim plan already developed.

The ratings coming through at six monthly reviews provide information on the level at which a person(s) may be deteriorating and alert the nurse manager to when additional observations or interventions may be required. The nurse manager is now using the data from the interRAI programme to identify any changes in acuity and therefore any required changes in staffing levels. In addition she is observing for trends across all residents to assess whether there are areas that might need attention. Communication was identified as one such area and staff training was implemented. Ideas from the 'Spark of Life' programme are used to try to remedy deterioration observed in the evaluation summary data both at the individual and service wide levels.

The owner/registered nurse, who is also a diversional therapist, has worked alongside the nurse manager in the development of service delivery plans for residents. She has now using the construct of the interRAI programme to help activities coordinators to redevelop the activity plans and their associated evaluation/review. This is contributing to service integration.

Finding:

The interRAI computer tool/programme is being used in a competent manner that demonstrates continuous improvement. On admission, interRAI is being consistently used for all residents for the completion of individualised assessments, the development of comprehensive service delivery plans and for the six monthly evaluations and reviews. Its use is ensuring all residents' needs are being met safely and holistically. Information and data from using interRAI is being used in innovative ways, such as for measuring acuity that justifies changes in staffing levels when necessary, to identify staff training needs and to compare areas where progress has been less than expected. This latter use is not just occurring at the individual level, but also to find and address areas for improvement service-wide. In addition, the framework of the interRAI programme is being used for the development of residents' activities plans

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures in relation to service delivery, as required by the ARRC agreement, are all present as noted in criterion 1.2.3.3.

The owner/registered nurse and the nurse manager both state they accept responsibility for the overall services delivered. Services are being delivered according to the service delivery plans that are consistent with the assessed needs of the residents. Two support partners confirm they use the service delivery plans to guide their work and that they are alerted to any changes at handovers and when they read the progress notes. A communication book alerts to any actual care plan changes and directs staff to read them.

Family members interviewed provide consistent feedback about the high quality of care and support provided, that the staff do it from their heart and just seem to know what to do and that staff handle all the challenges the residents present with in a patient and kind manner.

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:

As well as being a registered nurse, the owner/registered nurse is a qualified diversional therapist and oversees the three activities coordinators who work over seven days of the week. Each is at a different level of working towards their certificate in diversional therapy. The 'Spark of Life' approach that is identified as an area of continuous improvement in this service in standard 1.1.8 provides a framework for the activities programme, which is varied and flexible. Each activities plan in the nine personal records reviewed has relevant interventions and a space for review and evaluation. Since the implementation of the current system, there has not been time for reviews of these goals to have occurred. However there are also personalised monthly goals being developed for each resident that are more succinct and these are being reviewed on a monthly basis with an overview of the level of their attainment. Although it is recommended that the documentation around activities is more streamlined the service is meeting the required standards.

Monthly activities plans are being developed for both Adriel Rest Home and Adriel House, with the first one for the new Adriel House just having been completed. These plans show activities provided on a daily basis are meaningful to the people in these facilities with examples of both one on one and group options available. Combined morning teas and combined house sessions with residents at other rest homes in the region, outings, pikelet making, fishing, Men's club, Sunshine club, hand massage, walks, café visits and household tasks. In addition staff are observed to take advantage of incidental opportunities and it is observed how some of the women gravitate across to the diversional therapist who is peeling quince and within a short time several of the residents put on aprons and are assisting in various ways. Similarly an enlarged version of a word find is mounted on the wall and residents go across and attempt to work out words within the jumble of letters and in the other building a staff person sits and reads a book to a woman who is restless, while another receives a hand massage.

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents' service delivery/care plans are being evaluated by the registered nurse manager every six months. This is done in consultation with family, the owner/registered nurse and support partners as relevant. Full evaluations of care plans are sighted in seven of the nine care plans with the remaining two not having been in this service long enough for this to occur. The interRAI programme is used to assist with this evaluation and review process and a new care plan is developed according to the entries made into interRAI. The new care plan integrates any long term changes in requirements. Requirements of the ARC agreement are being met.

Support partners are being trained to write their progress notes according to the issues identified in the interRAI assessments and in the goals of the care plans and this is reportedly starting to contribute to better evaluations of the care plans. The change in the writing of progress notes towards using a more evaluative approach is becoming increasingly evident, as noted in the continuous improvement for 1.3.5.

Family members state that they are always being asked about how they think their relative is and are often invited to talk with the nurse about what care and support they want for their relative.

Interim care plans are developed for any problems that arise between full reviews and four examples of these are evident in the nine personal files reviewed. Examples sighted indicate they are used for infections, skin tears and an increase in falling. These interim plans are being evaluated daily, or at timeframes noted on the plan and the six monthly reviews include an assessment as to whether issues identified in interim care plans require integration into the long term plans.

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

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

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

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: In the personal records of residents that are sighted there is evidence of referrals made to a dentist, psychiatric services for the elderly, the diabetes nurse clinic, dentists and a dermatologist. The registered nurse informs that referrals are made to a local physiotherapist when required although there is not currently any person requiring this. Family members express confidence that all clinical/medical needs re being met and are satisfied that should their relative require any additional specialist assistance that this would be accessed.

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:

The nurse manager notes that residents do not generally transfer out of this service to another facility, except for a visit to hospital, and she could only think of one example, which was outside of the timeframe of the last audit. When a person needs to go into the Christchurch hospital a standard transfer form (sample sighted) is completed with basic information about the resident, a copy of the interRAI assessment, their medicine chart and sometimes a copy of their care plan. This documentation includes any potential risks and an overview of their management. A staff person or family member always accompanies the resident and a verbal handover from a registered nurse is provided.

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:

Medicine management policies and procedures sighted at stage one audit have been reviewed in September 2013. The procedures provided cover ordering and receiving medication, custody and storage of medication, controlled drugs, medicines reconciliation, administration of household remedies and alternative medicines, when a resident goes on leave, pro re nata medication, medication for short term residents, responsibilities, information about side effects, monitoring, staff training and different types of administration. An anti-microbial usage policy, one on medication errors and one on standing orders are also sighted, as is the medication competency assessment form.

Medicines are managed in Adriel House the same way as they are in the rest home. The nurse manager advises that because of the nature of the services provided, there are no policies and procedures on self-medication and no opportunities to self-medicate are offered.

All medicines are stored in a locked medicine room off the kitchen, which also has a key pad lock for entry. The medicines are also being stored in a locked medicine trolley. Medicines are picked up from the pharmacy on a monthly basis and any unused or expired medicine is returned at the same time.

Under the supervision and oversight of the registered nurse manager, an enrolled nurse, who is very aware of her scope of practice, has accepted responsibility for many aspects of medicine management. For example, the enrolled nurse trains staff for their medicine competencies in preparation for one of the registered nurses to do their assessments and reassessments, she undertakes the weekly controlled medicine checks with the registered nurse when they are required and works alongside her to assist with the monthly medicine reconciliation. The blister packages are initialled and the signing sheet is initialled to confirm they have been checked against each other and against the prescription.

There are not currently any controlled medicines in stock, however there is a locked steel cabinet attached the wall for them and the controlled drug register shows that two people have signed each one out and weekly checks have occurred when they were required.

Staff who administer medicines have completed medicine competencies and there is evidence of updated competencies in the staff files viewed.

Medicine administration is observed to follow best practice guidelines during observation of the mid-day medicine round in the rest home on day one of the audit. The support partner attends to hand hygiene, double checks the medicine against the prescription, states the name of the resident to another staff person as she went to administer the medicine and then signs the signing sheet. She is observed checking clearly documented individualised needs for administration that assist with compliance for some residents. Those that can be crushed are noted; as is the medium they can be administered with. The mortar and pestle are wiped between the crushing of different medicines. It is also noted that two people came from behind to speak with her and she advised both that she was administering medicines and would need to talk with another staff person.

Seven medicine records from Adriel rest home and four from Adriel House are reviewed. The allergy status of each is noted, and all medicines are prescribed by one of two local GPs. Sample signing sheets sit at the front of the medicine chart folder and on the monthly signing sheet for each person. Four of the eleven charts do not have any medicines signed and discontinued as they are new medicine recording charts. Similarly review timeframes are not evident as they have been in place for less than one month. The pharmacy signs the blister packs as evidence the contents have been checked against the prescription.

There are unopened eye drops stored in a vegetable fridge in the medicine room in Adriel rest Home. The fridge temperatures are being checked monthly.

Results of a medicine audit undertaken 15 May 2013 are sighted. Four areas for improvement have been implemented as a result of this audit as the issues are not evident in checks made during this audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>A comprehensive food service manual is sighted during stage one of the audit. The policy addresses food service, menu planning, food preparation, nutrition and hydration, weight monitoring, meal services, food hygiene and safe storage, kitchen cleaning, staff personal hygiene, food temperatures, left-over food, pest control and managing sleepless residents in relation to food that can be provided.</p> <p>Meals are provided according to a menu that has been reviewed by a dietitian. Meals in both the rest home and the house are identical, although are currently being cooked separately. The kitchen in Adriel House also prepares the meals for local delivery of meals-on-wheels. The report is sighted and notes a further review is not required until 2015. One minor corrective action about the number of vegetable servings has been addressed. The main meal is served at mid-day. During interview the cook advises that although the main meal is prepared by night staff the cooks have control of the foods to be prepared and follow the menu. The menu rotates six weekly and has summer and winter options, with the winter option only commencing two days prior to the audit.</p> <p>Other than four people who have diabetes and for whom staff are aware require healthy food options only, there are no other special dietary requirements. Two people have protein drinks provided twice daily and there are seven who require their meals to be soft/moullied.</p> <p>Most of the fresh vegetables are supplied by the owner/registered nurse. Supplementary vegetables, dry goods and dairy products are delivered. The cook takes the temperatures of the hot protein food daily and checks fridge temperatures every week on a Monday, the hot water temperature at the kitchen tap and that of the dish steriliser. The records are sighted. Food is stored according to best practise principles with labels and dates in situ. Fruit and baking is available for residents who become hungry between meals and staff make sandwiches when required. Waste food is disposed of in separate buckets for compost, for chickens and for general rubbish disposal.</p> <p>The cook has been at Adriel for less than a year and informs that kitchen staff are the same as the support partners, in that they are at a minimum required to undertake</p>

modules 1- 8 of the ACE training that includes food safety handling.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: <p>A waste management policy describes processes for Adriel. Information on storage and use of chemicals is sighted in the laundry policy and procedure documentation. Information on material safety data sheets, hazard identification and personal protective equipment are available in the health and safety manual (sighted). There is a separate policy on recycling for Adriel Rest Home Ltd.</p> <p>General waste is collected by the local rubbish collection contractors, however recycling is removed by the owner. Food waste is composted (as appropriate) or disposed of in the general waste.</p> <p>Chemicals are seen to be kept in the laundry which has keypad lock entrance. Staff report the door is kept locked at all times when there is no one in the room. This is verified to occur at audit. Chemicals are supplied by contract from an external company. They are on site monthly to check product requirements and provide training for staff. Staff training records and interviews reflect their knowledge of chemicals and safety requirements around their use. Data safety sheets are available for staff and staff interviewed are able to describe how and where to obtain this information if required. The hazard register was sighted and includes the potential harm relating to each identified hazard.</p> <p>Goggles, aprons and gloves are available and seen to be used by staff. Adequate supplies are maintained and restocked as necessary.</p>

Contractual requirements are being met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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 1.4.2: 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:

Ariel Rest home has a current building warrant of fitness (sighted) and expires on 01/10/2014. The new Adriel House has a certificate of public use, received from the Hurunui District Council. The service is waiting for their code compliance certificate which is due to arrive (sighted emails from the project manager – dated 31/3/14, verifying this).

Equipment checks are seen to be undertaken. Where equipment requires repair, this is undertaken and recorded.

Hot water testing is done monthly, last 31/3/14. All temperatures are noted to be within the required range to ensure the safety of the residents and staff, with the exception of the laundry where the water tested too hot. A plumber was called in to adjust the tempering valve.

Both homes are co-located on next door properties. They have level access and outside areas that are developed specifically for the safe use of the residents. Planting is still being completed on the Adriel house site but the paths are in place and allow for residents to safely mobilise within their ability. Ramps and handrails are in place where required, to facilitate this.

Sighted policy on transportation and vehicle usage policy. It is the responsibility of the owner to ensure the vehicle has a current warrant of fitness.

All contractual requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: Adriel Rest Home has five toilets, two of which are fully accessible. There are three showers and two of these are fully wheelchair accessible. A number of the residents have commodes in their rooms. Staff report using commodes for the residents at night time to minimise the risk of mobilising them to the bathroom at night. A separate

bathroom area has a three basin unit that residents can use.

Adriel House has two wings, each with two accessible toilets/showers as well as a separate toilet. The double room has an ensuite shower/toilet attached suitable for couples.

Each toilet and shower area has handrails and all are in close proximity to the bedrooms and the communal areas.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In Adriel Rest Home, most of residents have single rooms. There are three shared double rooms, but only two are currently in use. The majority of residents are fully mobile, although some use mobility aids. The bedrooms are noted to be clean and tidy and all are personalised according to individual preferences as appropriate.

There is one double room in Adriel House that is intended for the use of couples, and is currently not in use. The bedrooms are personalised according to individual preferences as appropriate.

Contractual requirements are met

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: Both homes have dedicated dining areas for residents to share a meal. A variety of living spaces are available to support the individual needs of the residents. Quiet areas are provided for residents to have visitors or be alone if they wish. Television is available for those who enjoy it. The living spaces provide the residents with comfortable seating, and are seen to be light and well ventilated with easy access to the safe outside spaces. All ARC requirements are met.

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures for laundry and cleaning processes are sighted during stage one of the audit. Schedules, procedures, equipment and chemical use are covered in the cleaning documents. The laundry ones cover sorting procedures, managing infectious and heavily soiled linen, chemicals, equipment and staff practices. Data safety sheets are readily available and accessible to staff.

Both cleaning and laundry support workers interviewed are able to describe their practice regarding chemical safety including the use of personal protective equipment, chemical dosing units to ensure the correct dilution of products as well as their training regarding the safe handling of these chemicals. All solutions and equipment used for cleaning and laundry processes are noted to be in locked areas accessible only to staff.

The policy documents include monitoring through random quality laundry audits against the Adriel policies and procedures. Audit results sighted verify this occurs and areas requiring improvement are identified and actioned.

Staff working in the cleaning and laundry areas are able to describe their tasks, safety information and monitoring. Both sights have separate laundry facilities with dirty to clean, flow to minimise cross contamination.

The laundry in Adriel Rest Home is in need of an upgrade to replace flooring, some shelving and the cabinet beneath the tub to ensure the surfaces are impervious to liquid to facilitate effective cleaning and minimise the infection control risk. This is noted to be included in the strategic plan for 2014 and the RN/owner confirms this is the priority now that Adriel House is completed.

Cleaning solutions and equipment are colour coded to aid service providers in using the correct processes (eg, different coloured buckets and mop heads are used for different reasons). Staff are able to describe the use of this equipment.

The requirements of the ARC are being met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: A list of contacts for specialist advice for managing specific hazards is sighted. There is a full set of policy and procedure documentation on emergency planning and readiness, a fire policy and evacuation plan, a range of adverse incidents such as a storm, flood and gas leak and civil defence procedures in the health and safety manual.

There is a fire service letter reporting on the latest trial evacuation 28/11/2013 and is noted to have taken 4 minutes 31 seconds. The next trial is scheduled for June 2014 and will include both sites. A fire service letter of approval of the evacuation scheme for Adriel House is available and dated 18 February 2014, with sprinkler compliance conformation also provided dated 11/3/2014. The facility keeps an updated list of residents and any special needs they may have in the event an evacuation is required (sighted). The RN/owner reports this is updated when there is any change to the residents in the homes or when a resident's mobility needs change and the NM and support staff are responsible for ensuring care plans describe the care and support required. Staff are required to complete first aid and fire training and attend trial evacuations to ensure they are competent to respond to emergency situations.

Alternative energy supplies that are available in the event of the main supplies failing include a gas barbecue for cooking purposes, several torches for lighting and spare blankets for warmth. Stocks of additional food and water are available. Adriel House also has a rain water tank installed to provide additional emergency water. A generator is available for use if required and is kept at the RN/owners house. Emergency equipment is checked monthly to ensure it is ready for use (last 31/3/2014).

The call bell system is of an older style, however is functional when tested. The residents inform during interview that call bells are answered and the one person who uses it at night confirms they are answered in a reasonable timeframe.

Security arrangements include locking doors, shutting windows and drawing curtains at nightfall. In Adriel house, the windows in residents' rooms have security stays on them that prevent them from being opened beyond a safe width. Sensor lights are installed around the outside of the facility. Combination locks are used on appropriate doors, although the front doors are key locked for security at night.

All ARC requirements are being met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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 1.4.8: 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:

There is a combination of heating across both sites and this includes wood fire, gas fires and electrical heating.

All resident rooms have an opening window to allow for light and ventilation.

Dining and living spaces are light and airy with large opening windows. All living spaces open onto safe outside areas which allow the doors to be kept open as desired.

ARC requirements are met.

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

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

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

A policy on restraint minimisation and safe practice (dated November 2013) is sighted during stage one audit. This policy defines restraint and lists the types of restraint with a brief statement of what each is. There are clear definitions of terms included in the policy documents including the definition of an enabler. Additionally, there is a diagram that helps discriminate between enabler and restraint.

The policy states restraint will only be used as a last resort and the least restrictive method will be used. Requirements to be considered when restraint is used at Adriel are described. This includes procedures around exploring options such as de-escalation, what is required in the care plan and the process for assessment, consent and review. Issues of considerations relating to cultural recognition and the requirements of staff training, its content and related competencies are also described. Other aspects covered include monitoring during restraint use, criteria for discontinuation of restraint, risk and quality management and the evaluation of restraint use. The role of the restraint coordinator and his/her job description is sighted. Also sighted is a Managing Challenging Behaviour policy, which describes assessment and monitoring processes.

Review of restraint episodes utilised indicate the service actively minimise the use of restraint and have robust processes and documents in place to support documentation and review of episodes should they be required. On average, two residents per year require some form of restraint. Only two of the current residents are using restraint.

The requirements of the ARC are met.

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 NM has overall responsibility for restraint in the service and is able to describe the processes required if the need for restraint is identified, including a GP assessment, completion of a restraint assessment form and the notification and involvement of the resident's family. The position description for this is in her personal staff file and was sighted. The position description describes the accountability process and the roles and responsibilities required of the position. The NM reports episodes of restraint and its use are discussed at the three monthly quality meetings. Minutes sighted verify a discussion occurs and any change in the policy, the requirements of individual residents or strategies employed to reduce the need for restraint, are discussed.

There are three forms of restraint that have been authorised and approved for use in this facility. These include lazy boy chairs, posture foam chairs and bedrails. Currently there are two current residents using restraint: one requires bedrails at night; and the other a lazy-boy-chair tilted to prevent the resident climbing out and falling.

Support workers interviewed verify they would approach the NM should they identify a need for a resident to be reviewed and assessed if they believe a restraint may be needed.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Consent is required from the NM, the GP and evidence of discussion and agreement from the resident's family is also included on the consent forms sighted.

A restraint assessment form ensures the resident is assessed against all aspects of the standard (as listed) prior to a restraint being approved. This is noted to be completed for both the residents currently being restrained.

Contractual requirements are met.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: PA Low

Evidence:

Staff interviews and training records sighted verify staff receive training on restraint annually – last in December 2013. The service focus on the ‘Spark of life’ philosophy has resulted in a noticeable decrease in incidents involving resident behaviour (see 1.2.4). Staff have received training in this philosophy and seen to be utilising techniques, such as distraction, that minimise the chances of an episode of challenging behaviour escalating.

A review of both the restrained residents’ files verify they have been assessed by both the NM and the GP and their need for some form of restraint is identified as appropriate to ensure their safety. Both are noted to attempt to mobilise independently and have a high falls rate when they attempt to do this. Discussions with the family are noted to have occurred prior to the restraint being implemented to ensure the relatives understand the process and need.

Each episode of restraint is documented according to the protocol, including the updating of the care plans to ensure support staff are aware of the monitoring requirements. Although this is seen to be completed, there is little or no documentation to verify the monitoring has occurred and this is identified as an area requiring improvement.

There is a register in place and is seen to be up to date. There are currently two residents receiving restraint and they are both seen to be included in the register. The register is seen to be updated when the resident no longer requires restraint or the resident is no longer with the service.

Contractual requirements are met.

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: PA Low

Evidence:

Although care plans are seen to note the monitoring requirements of residents undergoing restraint and all residents are noted to be mobilised at least two hourly to manage toileting and other care requirements, this is not consistently documented in the progress notes or any monitoring identified for the residents currently requiring the use of restraint.

Finding:

Monitoring of the restraint is included in care planning but is not clearly documented in the resident's progress notes that this has occurred.

Corrective Action:

Ensure observations and monitoring of residents is documented during the use of restraint.

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

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

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:

A Restraint Evaluation Form is available and noted to be completed in both the residents' files reviewed. The form includes timeframes for review and a list of considerations required to be completed by the NM. These are reported at both the quality meetings three monthly and monthly staff meetings to ensure all staff are aware of the residents' needs and have an opportunity to discuss and update any aspects of care.

The requirements of the ARC are met

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Restraint is a standard agenda item at the three monthly quality meetings. This is noted to be reviewed and discussions documented include on-going restraint requirements for the service. Incidents of challenging behaviour are monitored and strategies discussed in order to minimise the needs for restraint relating to challenging behaviour. Incidents and review of the use of restraints demonstrate restraint is used to ensure the safety of the resident relating to falls rather than behaviour. It is noted that, on average, there are two residents per year requiring restraint.

Contractual requirements are met.

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:
The structure of the infection control (IC) programme is described in policy documents. This includes the roles and responsibilities of the infection control committee, the infection control officer, management and staff. The NM is responsible for the implementation of the IC programme.
There is an annual report tabled at the first quality meeting of the year where a summary of the infection control programme from the previous year is discussed and any changes in emphasis, training or policy documents are discussed and minuted (Sighted the report for 2013).
Ways in which facility compliance with infection control standards are listed and include annual hand washing audits, routine environmental inspections, incident reports,

kitchen and laundry audits, food handling compliance and surveillance processes. Results of audits sighted demonstrate monitoring of processes occurs as per policy and any shortfalls are identified and addressed.

Staff are advised not to come to work if they have a suspected infection.

Visitors are discouraged from visiting if they are unwell and hand gel is available at the front entrance and throughout the facility for visitor use. The NM informs that they know the regular visitors/family members well and discuss any concerns with them should the need arise. The RN advises that in the service has notices to place on the door asking visitors not to enter if they have suspected outbreak of a disease such as norovirus. Alcohol hand gel is available at the entrance and throughout the facility and staff and visitors are encouraged to use it.

The requirements of the ARC 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The NM is responsible for the management and implementation of the infection control programme. The quality committee is also the infection control committee and IC is noted to be a standard agenda item at the quarterly quality meetings (minutes sighted).

The NM reports being in contact with Southern Laboratories, the local GP and the DHB infection control team should they need any advice regarding specific needs of the residents.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>A suite of infection control policies and procedures are sighted and meet the needs of this rest home (dementia) service. The policies guide staff in the programme including infection management, use of PPE, outbreak management understanding of infection control principles. Review of the policy documents identify a number of policies and procedures that are not dated and do not reflect current infection control terms and principles. This is an area requiring improvement.</p> <p>Staff interviewed are able to describe current best practice principles, such as hand washing, standard precautions, the use of alcohol hand rub and dirty to clean flow through the laundry.</p> <p>ARC requirements are met.</p>

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: PA Low
Evidence: <p>Although policies exist and staff are able to describe the principles and processes the service use in the implementation of the infection control programme, policy documents do not reflect current terms and language used in infection control and the review dates are not consistently included.</p>
Finding: <p>The programme and policies sighted are not consistently dated with current review dates and current terms used to describe infection control principles that reflect current best practice.</p>
Corrective Action: <p>Ensure policies and procedures are updated regularly and reflect current best practice</p>

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection prevention and control policy has a section on education that states the infection control officer performs ongoing education at least annually, that records of attendance will be in staff files and notes that a module of the Aged Care Education programme includes infection control.

The NM has attended infection control update training provided by 'Bug Control' and receives updates. She reports having ready access to the Southern Laboratory staff, the GP and the infection control team at CDHB if she requires advice or support.

The policy also notes all new staff will receive education on infection prevention, hand washing, standard pre-cautions and related policies and procedures. Staff education records sighted includes education on Infection control principles and that include hand washing, laundry processes, separation of waste and the use of PPE. The last training provided was November 2013 (12 staff attended).

Contractual requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Surveillance of infection at Adriel is described in the infection control policy and procedures. This notes how infections will be recorded, analysed and monitored and lists those to be included in the surveillance records as urinary tract, lower respiratory tract, skin and soft tissue, influenza and eye infections. There is an accompanying document on the general identification and prevention of infection and the policy states they will also monitor and report any incidence of multi-drug resistant organisms.</p> <p>There is a list of infections along with a reference guide and definitions by McGreer. It is recommended the service streamline this information and incorporate it into the surveillance policy to make it more readily accessible and understood by support staff.</p> <p>Infections are identified through the results of swabs or samples sent to the laboratory. Results are sent to both the service and the GP. Where it is not possible to take a sample, staff assess any change in resident's behaviour and/or other associated signs or symptoms to determine whether an infection is present.</p> <p>Surveillance records sighted demonstrate the service is keeping a record of infections and identifying and analysing any trends in order to determine if changes need to be made to their processes or the management of the resident. These are collated monthly and the results reported to the staff at the monthly meetings and to the quality team three monthly to discuss any changes in the care needs for the residents.</p> <p>ARC contractual requirements are met.</p>

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

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

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

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

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

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