# Bryant House Limited

## Current Status: 18 March 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Bryant House is a 33 bed facility located in Napier providing rest home level care. At the time of audit there are 33 residents receiving care. The owner purchased this rest home in November 2007 and actively works in the resthome as the facility and operations manager. There have been no changes to the services, building or environment since the last audit with the exception of an electronic/automatic gate being installed. The clinical manager has recently changed, with a previously employed clinical manager returning to the role in February 2014. The clinical manager is supported by a registered nurse. Both are working full time at Bryant House.

At this audit there were eight areas identified as requiring improvement. These include documentation of advance directives; ensuring documentation about residents’ enduring power of attorney is accurate; secure storage of residents’ records; ensuring residents’ lifestyle care plans include individualised management strategies for challenging behaviours; and evaluation of residents’ progress in achieving goals and response to wound care interventions. Improvements are also required in relation to medication standing orders and ensuring all medications are stored securely; performance monitoring of equipment and bathroom maintenance; and ensuring a staff member with a current first aid certificate is on duty at all times.

## Audit Summary as at 18 March 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 18 March 2014

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| 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 18 March 2014

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

### Continuum of Service Delivery as at 18 March 2014

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

### Safe and Appropriate Environment as at 18 March 2014

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

### Restraint Minimisation and Safe Practice as at 18 March 2014

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

### Infection Prevention and Control as at 18 March 2014

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

## Audit Results as at 18 March 2014

### Consumer Rights

Staff at Bryant House implement processes that demonstrate a commitment to ensuring residents’ rights are respected at all times. As observed, staff knowledge and understanding of residents’ right is embedded into everyday practice. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) clearly displayed in the facility.

Residents are provided with care and services that allow them to maximise their independence and to ensure their needs are met. Resident and family interviewed confirmed their satisfaction with the staff and provision of services. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination. Family members interviewed stated they have never observed any staff conduct that has caused them any concern. All family and residents interviewed commended staff for providing a ‘caring home’ environment.

There a Maori Health Plan in place that identifies how the service responds to residents who identify as Maori. At the time of audit there were three residents who identify as Maori or another ethnicity. Recognition and respect for all individual’s cultural, values and beliefs is well managed by the service and clearly documented during the assessment and care planning process.

Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice with specialist input as is appropriate. Documentation and interviews confirmed there is effective and honest communication between service providers, other health professionals, such as the podiatrist and medical specialists, residents and family. Residents have visitors of their choice and are actively encouraged to maintain links with family, friends and community.

Processes are in place to obtain residents’ written informed consent. An area requiring improvement relates to ensuring advance directives meet legislative requirements.

The right to make a complaint was well understood by residents and family members interviewed as well as staff and the owner/manager. Complaints are infrequent and are well managed.

### Organisational Management

The service is privately owned, and one of the owners is also the general manager. The scope, direction, values and objectives of the services are clearly articulated, and the systems and processes associated with monitoring and reporting all aspects of the service are well developed.

The general manager and the full time clinical manager are suitably qualified and experienced for their roles. Appropriately qualified staff are available to cover these positions during periods of temporary absence.

The service has well established quality and risk management systems, including a comprehensive programme of internal auditing. The Quality and Risk Management Committee, which is effectively the senior management team, has oversight of all aspects of service management. Adverse events are reported, investigated and notified appropriately.

Comprehensive staff training is offered, and there is good attendance at education sessions. The service is appropriately staffed, with two registered nurses available on week days, and then on call 24 hours a day, seven days a week. The retention of a number of long-term staff is a strength of the organisation, with at least four staff working at Bryant House for between 17-32 years.

Resident information not in current use (archived) is stored securely and privacy of information is maintained. Resident information in current use are kept in a small office that is frequently left open when unattended, and this is identified as an area requiring improvement. Records are made in residents’ files at least every shift. Ensuring documentation related to enduring power of attorney is accurate is an area requiring improvement.

### Continuum of Service Delivery

The service maintains documented entry criteria and there are processes in place should a resident be declined service. At the time of audit the service has not declined entry where the resident has an appropriate assessment and an appropriate bed is available.

Residents receive timely, competent and appropriate services by experienced staff. Care is co-ordinated by the registered nurse (RN)and the care manager (also a RN) who both work on site week days and share after hours on call.

Assessment, care planning, review and evaluation of care provided and resident needs is occurring. The care plans do not provide guidance on how caregivers are to manage residents’ challenging behaviour and this is an area requiring improvement. Despite this, appropriate care is being provided as the residents’ care needs are being effectively communicated via other methods, including shift handover. Not all evaluations are sufficiently detailed or provided evidence of progress for the resident towards achieving their goals. This also requires improvement.

Resident and family input into planned care is well documented. Family meetings are routinely scheduled at least six monthly or sooner where appropriate. Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

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

Residents receive medicines in a timely manner. Medications are kept securely, with the exception of nasal sprays and eye drops and this is an area requiring improvement. The medication standing orders are in the process of being updated to align with current accepted standards. This is work in progress and an area requiring improvement. Staff who undertake medicine administration hold appropriate competencies.

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

### Safe and Appropriate Environment

Bryant House provides a safe, appropriate and homely environment for its residents. The building complies with legislative requirements, and there is easy access and egress for residents and their families. There are several outside areas for residents to access, and residents were observed making full use of these. There are adequate numbers of toilets, shower and hand washing facilities. Residents’ rooms are single occupancy (although there are several rooms that could accommodate couples if this is required) and personalising of these rooms is encouraged. All resident areas have adequate lighting and ventilation.

Appropriate systems and resources are in place to respond to emergency situations, and staff were familiar with emergency protocols. The scheduled testing of electrical and clinical equipment, the maintenance of toilets and showers, the cleaning of bathrooms, and ensuring a staff member with a current first aid certificate is always on duty are identified as areas requiring improvement.

### Restraint Minimisation and Safe Practice

Bryant House has a restraint free philosophy, and restraints have not been used in the past six years. This is identified as a strength of the service. Systems, including detailed policies and procedures, are in place should restraint be required. Staff have received regular and ongoing training related to restraint.

### Infection Prevention and Control

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Responsibilities for implementing the infection prevention and control programme are shared between the registered nurse and the clinical manager who both participate in relevant ongoing education.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the clinical manager. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Residents are offered annual influenza vaccinations (with prior consent). There have been no reported outbreaks of infections at this facility since the last audit.

# 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**

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| --- | --- |
| **Legal entity name:** | Bryant House Limited |
| **Certificate name:** | Bryant House Limited |

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| **Designated Auditing Agency:** | The DAA Group Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Bryant House | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 18 March 2014 | **End date:** | 19 March 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 33 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 4 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 20 | Total audit hours | 52 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 10 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 13 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of 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 |  |
| 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 Friday, 11 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Bryant House is a 33 bed facility located in Napier providing rest home level care. At the time of audit there are 33 residents receiving care. The owner purchased this rest home in November 2007 and actively works in the resthome as the facility and operations manager. There have been no changes to the services, building or environment since the last audit with the exception of an electronic/automatic gate being installed. The clinical manager has recently changed, with a previously employed clinical manager returning to the role in February 2014. The clinical manager is supported by a registered nurse. Both are working full time at Bryant House.  At this audit there were eight areas identified as requiring improvement. These include documentation of advance directives; ensuring documentation about residents’ enduring power of attorney is accurate; secure storage of residents’ records; ensuring residents’ lifestyle care plans include individualised management strategies for challenging behaviours; and evaluation of residents’ progress in achieving goals and response to wound care interventions. Improvements are also required in relation to medication standing orders and ensuring all medications are stored securely; performance monitoring of equipment and bathroom maintenance; and ensuring a staff member with a current first aid certificate is on duty at all times. |

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| **Outcome 1.1: Consumer Rights** |
| Staff at Bryant House implement processes that demonstrate a commitment to ensuring residents’ rights are respected at all times. As observed, staff knowledge and understanding of residents’ right is embedded into everyday practice. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) clearly displayed in the facility.   Residents are provided with care and services that allow them to maximise their independence and to ensure their needs are met. Resident and family interviewed confirmed their satisfaction with the staff and provision of services. Policies, procedures and process are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination. Family members interviewed stated they have never observed any staff conduct that has caused them any concern. All family and residents interviewed commended staff for providing a ‘caring home’ environment.  There a Maori Health Plan in place that identifies how the service responds to residents who identify as Maori. At the time of audit there were three residents who identify as Maori or another ethnicity. Recognition and respect for all individual’s cultural, values and beliefs is well managed by the service and clearly documented during the assessment and care planning process.   Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice with specialist input as is appropriate. Documentation and interviews confirmed there is effective and honest communication between service providers, other health professionals, such as the podiatrist and medical specialists, residents and family. Residents have visitors of their choice and are actively encouraged to maintain links with family, friends and community.   Processes are in place to obtain residents’ written informed consent. An area requiring improvement relates to ensuring advance directives meet legislative requirements.  The right to make a complaint was well understood by residents and family members interviewed as well as staff and the owner/manager. Complaints are infrequent and are well managed. |

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| **Outcome 1.2: Organisational Management** |
| The service is privately owned, and one of the owners is also the general manager. The scope, direction, values and objectives of the services are clearly articulated, and the systems and processes associated with monitoring and reporting all aspects of the service are well developed.  The general manager and the full time clinical manager are suitably qualified and experienced for their roles. Appropriately qualified staff are available to cover these positions during periods of temporary absence.   The service has well established quality and risk management systems, including a comprehensive programme of internal auditing. The Quality and Risk Management Committee, which is effectively the senior management team, has oversight of all aspects of service management. Adverse events are reported, investigated and notified appropriately.  Comprehensive staff training is offered, and there is good attendance at education sessions. The service is appropriately staffed, with two registered nurses available on week days, and then on call 24 hours a day, seven days a week. The retention of a number of long-term staff is a strength of the organisation, with at least four staff working at Bryant House for between 17-32 years.  Resident information not in current use (archived) is stored securely and privacy of information is maintained. Resident information in current use are kept in a small office that is frequently left open when unattended, and this is identified as an area requiring improvement. Records are made in residents’ files at least every shift. Ensuring documentation related to enduring power of attorney is accurate is an area requiring improvement. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service maintains documented entry criteria and there are processes in place should a resident be declined service. At the time of audit the service has not declined entry where the resident has an appropriate assessment and an appropriate bed is available.   Residents receive timely, competent and appropriate services by experienced staff. Care is co-ordinated by the registered nurse (RN)and the care manager (also a RN) who both work on site week days and share after hours on call.  Assessment, care planning, review and evaluation of care provided and resident needs is occurring. The care plans do not provide guidance on how caregivers are to manage residents’ challenging behaviour and this is an area requiring improvement. Despite this, appropriate care is being provided as the residents’ care needs are being effectively communicated via other methods, including shift handover. Not all evaluations are sufficiently detailed or provided evidence of progress for the resident towards achieving their goals. This also requires improvement.   Resident and family input into planned care is well documented. Family meetings are routinely scheduled at least six monthly or sooner where appropriate. Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.    The service provides planned and spontaneous activities for all age groups and needs levels. The residents are involved in this process to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests (including cultural).  Residents receive medicines in a timely manner. Medications are kept securely, with the exception of nasal sprays and eye drops and this is an area requiring improvement. The medication standing orders are in the process of being updated to align with current accepted standards. This is work in progress and an area requiring improvement. Staff who undertake medicine administration hold appropriate competencies.  Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements, including cultural and personal likes and dislikes. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Bryant House provides a safe, appropriate and homely environment for its residents. The building complies with legislative requirements, and there is easy access and egress for residents and their families. There are several outside areas for residents to access, and residents were observed making full use of these. There are adequate numbers of toilets, shower and hand washing facilities. Residents’ rooms are single occupancy (although there are several rooms that could accommodate couples if this is required) and personalising of these rooms is encouraged. All resident areas have adequate lighting and ventilation.   Appropriate systems and resources are in place to respond to emergency situations, and staff were familiar with emergency protocols. The scheduled testing of electrical and clinical equipment, the maintenance of toilets and showers, the cleaning of bathrooms, and ensuring a staff member with a current first aid certificate is always on duty are identified as areas requiring improvement. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Bryant House has a restraint free philosophy, and restraints have not been used in the past six years. This is identified as a strength of the service. Systems, including detailed policies and procedures, are in place should restraint be required. Staff have received regular and ongoing training related to restraint. |

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| **Outcome 3: Infection Prevention and Control** |
| There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Responsibilities for implementing the infection prevention and control programme are shared between the registered nurse and the clinical manager who both participate in relevant ongoing education.  Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.   Infection control education is provided by the clinical manager. The education is relevant to the service setting.  The type of infection surveillance undertaken is appropriate to the size of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Residents are offered annual influenza vaccinations (with prior consent). There have been no reported outbreaks of infections at this facility since the last audit. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 39 | 0 | 5 | 2 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 6 | 2 | 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 | 4 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |

## **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 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | Advance directives are sighted in three of ten residents’ files which have been signed by family members, in variance with legislative requirements and the organisation’s policy. | Ensure advance directives are only signed by competent residents. | 180 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.1 | Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | In the front of residents’ files there is an area used to identify who the preferred contact is. Staff are also documenting whether the resident has an enduring power of attorney in place and whether this is for property and finance or care/welfare. The information is in-correct in two residents’ files sampled. As an example the residents record notes the family member has EPOA for care and financial matters. The copy of the EPOA on file relates only to property. | Ensure records related to EPOA are accurate and copies are available on file where these exisit. | 180 |
| HDS(C)S.2008 | Criterion 1.2.9.7 | Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. | PA Low | Resident information not in current use (archived) is stored securely and privacy of information is maintained. Resident information/files that are in current use are kept in a small office that is left open when unattended. | Ensure that all resident information is maintained securely and confidentially. | 180 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| 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. | PA Low | There is currently no information included in two resident’s care plans in relation to managing the residents challenging behaviours. Missing from the careplans are the known triggers for these episodes of challenging behaviour, individulised de-escalation /distraction activities and ongoing management. | Ensure care plans are sufficiently detailed to guide all aspects of care. | 180 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Evaluations of residents’ progress in achieving their goals is not consistently evident in the residents’ files sampled. There are some examples of sufficiently detailed evaluations. Other examples include NAD (nothing abnormal detected), satisfactory or commentary that does not include all relevant componants. There is only a small area for evaluations to be documented in the care plans in use.  While wound care plans are developed and woundcare is signed as being undertaken; missing is evaluation of the appearance and state of the wound (pressure area).. | Ensure all evaluations of resident progress to achieving goals are sufficiently detailed and include all relevant and current information. Ensure evaluations are documeted that demonstrate the ongoing condition of wounds and progress or otherwise in healing/managing the wound. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The medication standing order has been recently revised to align with the new national standing order requirements. These have not yet been signed by the prescribers. The current standing orders (using the old format) were last reviewed and signed by the general practitioners in December 2012.  Nasal sprays and eye drops are being stored on the top of the medication trolley in the nurses’ cupboard which is unlocked. | Make the final ammendments to the new draft medication standing orders and obtain prescribers review and sign off.Ensure all medications are storeed securely. | 90 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | Electrical equipment is not regularly tested, and a schedule for testing has yet to be developed  Clinical equipment, such as blood pressure monitors and weighing scales do not currently have performance monitoring checks completed. There is no planned maintenance schedule to ensure that toilet/showers and bathing areas in the facility, or equipment such as shower chairs, are maintained appropriately. Minor repair work is required to maintain impervious surfaces, and to facilitate thorough cleaning. | A schedule is developed and implemented to ensure that all electrical equipment is regularly tested, and medical equipment has performance monitoring checks completed. Address all outstanding maintenance issues, and develop a planned maintenance schedule for the future. Ensure that the facility cleaning schedule includes all required cleaning in the bathroom/toilets areas, and this is monitored. | 180 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is not a staff member with a current first aid certificate on duty at all times. | Ensure there is a staff member with a current first aid certificate on duty at all times | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering resident bedrooms, use residents’ preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (six of six staff from across the service) confirm they respect the resident’s right to refuse cares or interventions. Staff can verbalise and were observed dealing with situations that arise which ensure residents’ rights are maintained. This is confirmed during interviews with six of six residents and five of five family members.   Eighteen staff are documented as attending training on the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers' Rights (the Code) in 2013 in education records sighted.  The Age Related Residential Aged Care (ARRC) requirements are met. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policies and procedures sighted verify that the Code of Rights will be met by the organisation. This includes ensuring residents’ individual cultural and spiritual needs are met. The policy details how this will occur and includes ensuring new residents and family are informed of the rights as a component of the admission process. Ensuring staff participate in training on the Code is also a requirement. The policies detail what the ten rights of residents are. Policy notes interpreters will be used as required and if a resident is unable to read, the staff member admitting the resident is to read the Code and offer opportunity for discussion.  The policy notes a copy of the Code and information on advocacy services will be on display.  Stage two: Opportunities are provided for explanations, discussion, and clarification about the Code with the resident and family/whānau as part of the admission process. The Code is available on site in DVD (sighted). The clinical manager (CM) advises the Code can also be obtained off the internet if required in other languages.   As observed, contact information for the Nationwide Health and Disability Advocacy Service is contained in the information given to residents during admission and the Code and independent advocacy services brochures are available in the facility (at the main entrance). Interviews with six of six residents and five of five family members confirm they are informed of their rights and that staff always respect all aspects of their rights. This is supported during interview with the GP.  ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policy documents state residents right for privacy including physical, auditory, privacy of records and personal property. Guidance is provided for staff on how this is achieved. Staff are required to knock before entering a resident’s room. The policy notes a telephone is available for resident use.  Policies provide guidance for staff in relation to sexuality and intimacy. The policy supports the rights of competent residents to develop or maintain intimate relationships. The policy also notes staff responsibility to ensure the safety and dignity of all residents and how ‘maladaptive behaviour’ is to be managed to ensure the safety of all residents.  ‘Bryant House policies identify that every resident is an individual and as such has different needs in relation to ethnicity, culture and spiritual values and beliefs. Culture, ethnicity, spirituality, values and beliefs provide an individual with a blueprint for how to lead their lives’. The resident and/or family whanau are to be consulted regarding the cultural/spiritual protocols to be observed and cultural/spiritual taboos to be avoided in the provision of care and services as part of the admission process.  The independence and individuality policy notes the organisation’s philosophy to maximise the resident’s independence and promote personal individuality. This is defined and guidance is provided for staff on how this can be attained. The importance of resident participation, choice and consent is detailed.  Specific needs are assessed during admission assessment and documented on care plan which is to be evaluated at least every six months or earlier if needed.   The discrimination policy includes the right of residents to be free from abuse or neglect. Definitions of the various types of abuse and neglect are included. The process for managing any suspected episodes of abuse and neglect is included.  Stage two: The environment allows for residents’ physical, visual, auditory and personal privacy to be respected. All rooms are single occupancy. There are a number of rooms which shared an adjoining ensuite. There are privacy locks on both entrances to the ensuite.  Resident’s needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in six of six resident file reviews which identify interventions put in place to match identified needs. Examples include having the priest visit to provide communion. Another resident is teaching staff phrases in Maori. The activities coordinator advised February was a month which included celebration of culture. This included the Treaty of Waitangi.  Resident services are provided in a manner that maximizes each resident’s independence and allows choices to be respected. Examples are documented in six of six care plan reviews and identified during interview with six of six residents, all five family members, the RN (registered nurse) and the CM. Residents’ are sighted mobilising freely inside and outside the rest home grounds independently (including using mobility devices). Residents are also sighted being taken on outings by family members and by the activities coordinator.  Residents and family report that they are treated with respect and that residents receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. All six residents and all five family members interviewed state they have never seen or heard a staff member interact with a resident in a manner that caused any concern. Rather, the residents and family speak highly of the staffs patience and caring attitude including where a resident is exhibiting challenging behaviour. Staff are observed during audit being careful during care. This included a staff member being observed carefully fitting a resident’s hearing aids and others assisting patients with their meals and mobilising.  ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The consumer rights - recognition of Maori policies and procedures states ‘ Bryant House Rest Home will endeavour to meet the health and disability needs of residents who identify as Maori in a manner that respects and acknowledges their individual cultural values and beliefs while maintaining a high standard of care.   Bryant House Rest Home is committed to the Treaty of Waitangi as it provides a framework for working in partnership with all people. Partnership, Participation and Protection underpin any Maori health strategies developed and incorporates a holistic approach to care: Whanau, Tinana, Hinengaro & Wairua. The Bryant House Maori Health Plan involves five processes including consultation, admission, managing care and finally Maori tanga training and employment. Residents will be encouraged to maintain contact with their own iwi and whanau. Maori support, advocacy and interpreter services will be made available to the resident, if applicable, along with a list of acceptable Maori Health Providers.  The policies note resident and whanau will be consulted about individual values, beliefs and needs during the admission and interpreters will be utilised as necessary. The policy provides guidance to staff on aspects of Tikanga best practice. Staff training on the provision of culturally appropriate care is included in the policy as a component of orientation and at least two yearly in the ongoing education programme. A review of how resident’s needs are being met will occur at least six monthly during care plans reviews and also during patient satisfaction surveys and via the quality and risk programme.  Stage two: The RN and activities coordinator identifies that currently there are two residents of Maori descent/ethnicity in the rest home. One of the residents is interviewed and confirms staff are providing culturally sensitive care. The resident is currently teaching staff and residents some Maori words/phrases. A poster is sighted in the main lounge with the English and Maori words for various colours. The resident advises family participation is encouraged.   The clinical manager reports that there are no known barriers to Maori accessing the service. Residents’ are informed as part of the admission process that they can have an advocate with them at any time. The resident advises access is available to Kaumatua or others for cultural supports if this is wanted.  The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with the RN and four of four caregivers and the activities coordinator. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents.   ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage two: Interviews with six of six residents and five of five family members confirm they are consulted on their relative’s individual values and beliefs and that care is planned and delivered to meet identified needs. This covers social, spiritual, cultural and recreational needs. Family are encouraged to be involved in the development and review of the care plan at admission and via attending six monthly care review meetings with key staff. This is verified in residents’ files sampled. One Rarotongan and two Maori residents have their cultural needs clearly stated on their care plans and activities plans.   The ARRC requirements are met. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The discrimination policy notes ‘It is policy that all Bryant House Rest Home employees and residents work together to create an environment that is safe, secure, peaceful and hospitable. Residents shall have the right to be safe from abusive behaviour and management has a duty of care to all who live and work within the Bryant House community. No resident shall be subjected to verbal, psychological, physical, institutional, sexual or material abuse. Management will ensure that procedures are established to prevent such abuse and are in place if an incident of abuse is reported’.  Other policies note the ‘house rules’ are discussed as part of orientation.  Stage two: Interviews with four of four caregivers, the activities coordinator, the cook, the RN, the CM, six of six residents, five of five family members and the GP confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. Staff acknowledge the resident’s right to say no or to refuse treatment or care. One resident (family member is also present) advised if she didn’t want a shower she ‘just said no and that’s all there is to it’. All residents’ and all family members interviewed advise they are very happy with all aspects of services provided. The staff interviewed confirm they are aware of the expected conduct.  There is a stable staff with a number of staff having worked in the facility for over 15 years. As examples the cook has been employed 19 years, the activities coordinator has worked in the facility for 32 years, the household coordinator has been employed 21 years and a senior caregiver employed approximately 17 years.  A police youth aid officer attended the facility on 16 March 2014 and spoke with residents about a variety of issues including crime prevention.  The CM advises independent advocacy services were obtained to assist a resident with ‘family related challenges’. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The good practice policy states ‘It is the policy of Bryant House Rest Home to conduct business at all times in a manner that encourages good practice. This policy ensures Bryant House Rest Home is admitting residents that they are able to provide a high quality of service to. To maintain high standards the Bryant House environment encourages good practise by ensuring all staff are fully trained with professional development and/or ongoing training is available, that the environment is safe, hazard free and clean. Also all residents are free from harm of any kind and that their cultural and individual values are acknowledged.’  Stage two: Interviews with four of four caregivers and the RN confirm that the environment in which they work encourages good practice. All staff have access to current policies and procedures. Appropriate ongoing education and support services and persons, such as the nurse specialists (NS) from the District Health Board (DHB), laboratory staff and the GP are available to staff. The CM and RN attend infection prevention and control meetings at the DHB.   Recognised industry approved care guidelines are utilised as appropriate, such as continence management, and review and management of variances in residents' vital signs, and a focus on falls risk reduction. The GP advises residents are prescribed osteoporosis reduction/prevention medications and staff work to minimise the impact of change during a patient’s transition from the DHB hospital to the rest home. The medication standing orders are under review and are being reformatted to align with the national standing order guidelines. This has not been completed as yet and is raised as an area for improvement in 1.3.12.1.   Interviews with six of six residents and five of five family members confirm their satisfaction with all care delivery and staff attitude.   ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The communication policy notes interpreters will be obtained where the resident’s second language is English or at request (via DHB switchboard). Open communication and disclosure are required by staff. Open disclosure is defined in the policy.  Stage two: Policy related to open disclosure is implemented by the service. Interviews with five of five family members confirm they are kept informed of the resident's status, including any adverse events/incidents, infections, changes in medication and or health status or any other concerns staff may have. Family notification is clearly documented in all six residents’ files sampled. The service encourages residents and family to be fully involved in the care planning process as appropriate. Six monthly family care meetings are scheduled and held giving staff and family members the opportunity to discuss and issues and/or priorities for ongoing care. A random review of three incident reports by the second auditor and the corresponding resident’s notes verifies open disclosure occurred for all three events.  The family member of one resident audited confirms participating in several meetings with staff to discuss the decline in health of her mother and the referral requesting reassessment of the resident’s level of care.  The GP confirms there is appropriate communication between Bryant House staff and the GP and other health professionals involved in each resident’s care.  If necessary, interpreter services are obtained via the DHB. Staff report this is very rarely required. Previously a resident from the Philippines spoke minimal English. Staff advise ‘key phrases’ were documented with the assistance of the resident’s daughter to aid communication.   A resident advises having conversations with the owner and clinical manager about the possibility of residents having access to Skype to help keep in touch with family.   ARRC requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Stage one: The informed consent policy notes Bryant House Rest Home is committed to ensuring that residents, their family/whanau and/or advocate, are provided with all necessary information, and understanding of that information (whether written or verbal) regarding treatment/care (including palliative),in order for informed consent to be given. Bryant House will ensure that the resident is of sound mind and able to give informed consent. Where this is not the case informed consent can be given by a recognised guardian or by an advance directive. There is a written consent form which is to be completed at admission which includes consent for the collection and storage of health information, the use of a photograph, use of transportation and treatment. Additional specific consent forms are reported to be used for specific procedures.  Stage two: Six of six residents and five of five family members confirm they are providing informed consent. All six residents have written consent forms in file providing consent for management of health information, obtaining and use of photographs, care delivery based on the residents assessed needs and use of facility transportation. In the front of the file information is recorded on whether the residents have an enduring power or attorney or a welfare guardian. This information is not accurate in two of six residents’ files reviewed and is raised as an area for improvement in 1.2.9.1. Verbal or written consent is sighted in residents’ files for the annual influenza vaccination.  The advance directive form includes an area for the resident or family member to sign in variance to legislative requirements. Family members are sighted to have signed advance directives for three of ten residents whose records are reviewed at audit. This is an area requiring improvement.  ARRC contract requirements are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Stage one:The advance directive form includes an area for the resident or family member to sign in variance to legislative requirements.  Stage two: Advance directives are sighted in three of six resident files that have been signed by family members, in variance with legislative requirements and the organisation’s policy. The sample size was expanded and a further four residents’ files reviewed. In total three of ten residents’ files sampled have advance directives signed by a family member. This is an area requiring improvement. |
| **Finding:** |
| Advance directives are sighted in three of ten residents’ files which have been signed by family members, in variance with legislative requirements and the organisation’s policy. |
| **Corrective Action:** |
| Ensure advance directives are only signed by competent residents. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policy notes resident’s rights to advocacy services – including from family/whanau or independent advocate. Where a resident is unable to represent their needs an advocate will be obtained. Information on independent advocacy services is to be provided to residents and family/whanau during admission. Visiting hours are to be flexible to suit the needs of residents without compromising the safety and rights of other residents.   Stage two: Six of six resident file reviews and interviews with six of six residents and five of five family members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family is encouraged to involve themselves as advocates as appropriate. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and brochures are available in the main entrance. Staff interviews confirm the right of residents to nominate who they wish to advocate on their behalf at any time. The RN advises an independent advocate was obtained to assist a resident with some personal family challenges. The staff advises an HDC advocate has attended and provided in-service training for staff and then spoke with residents and family members.   ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policies identify that residents have access to services within the community that may represent their particular spiritual, cultural or religious belief. Where possible and within reason, Bryant House will try to facility the celebration of a festival/occasion of a residents as long as the rights, comfort and safety of other consumers is not compromised.  Visitors will be asked to sign a ‘visitor’s book’.  Stage two: The service has unrestricted visiting hours. Interviews with six of six residents confirm they have access to visitors of their choice. Five of five family members interviewed confirm that they are always made to feel welcome regardless of the time of day or night they may visit. The visitors and family members advise they have open/unrestricted access to the owner, clinical manager or RN, and are sighted ‘popping in’ throughout the day.  Residents are encouraged and supported to maintain and access community services along with friends and family members. Representatives from the Anglican Church visit monthly; representatives from the Catholic Church visit weekly; and residents are invited offsite to the Presbyterian Church once a month for morning tea and fellowship. Residents have the opportunity of attending the Returned Services Association (RSA) once a month and this outing occurred during the audit. Residents are sighted being asked and giving verbal consent to attend.  Documentation sighted in six of six resident files identifies that community contact is maintained with support groups such as local church groups and the RSA. Residents, who are able, go out shopping independently to local shops and/or with family as they wish.   On the days of audit residents were seen coming and going as they wish. One resident is going out with family to a Café for lunch, another two residents are going out for a walk (exercise) and another resident is sighted leaving the property on a mobility scooter.   ARRC requirements are met. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: The complaints policy details the right of residents, family/whanau, advocates or other health providers to make a complaint. All verbal complaints are to be documented. The responsibilities of staff and management in responding to complaints is detailed and includes timeframes which meets the requirements of the Code. Complaints forms are prominently displayed in the entrance foyer.   Bryant House received one resident/family complaint in 2013, and one to date in 2014. A complaint was also received from a staff member in 2014. All complaints were managed in accordance with the policy, including required timeframes, and documentation of investigation outcomes and follow-up. A complaints register is maintained.  On interview seven of seven staff confirm their understanding of the complaints process, and their role in this. All residents and families interviewed also demonstrate understanding of the complaints process. In the 2013 resident/family satisfaction survey, the complaints process received a 91% satisfaction rating. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: A governance policy details desired outcomes, organisational structure, and processes associated with governance.  The organisation’s business plan and quality and risk management systems policy, clearly identify the purpose, values, scope, direction and goals of the organisation, and a strong commitment to resident-centred care. This is reflected in the mission statement of the organisation: ‘every day we strive to assist our residents to live life to the full whilst maintaining their dignity, independence and sense of purpose in a safe and caring environment’. The organisation seeks to include the views of residents and families in confirming its values (sighted in resident/family meeting minutes).   The business plan (current plan is for the 2014/2015 period) is formally reviewed annually, but is also reviewed informally on an as-required date. The organisational governance structure is outlined in the governance policy(sighted) with a three-person board of directors (the two owners, and one non-executive director). One of the owners is also the general manager. The organisational chart (sighted) establishes the relationship between the Board, and the senior management team (also known as the Quality and Risk Management Team), consisting of the General Manager, Clinical Manager, Household Coordinator, Senior Caregiver, Diversional Therapist and Food Services Manager. This team meets monthly, and as-required (meeting minutes sighted).   The Owner/General Manager has been in the role for six years, and attends professional development specific to managing aged care facilities. He is also a member of the executive of the New Zealand Aged Care Association in Hawke’s Bay. The Clinical Manager has been in her role for two months. She worked at the facility for five years (the last year as clinical manager) prior to taking a fourteen-month break, returning again earlier this year. She has completed a management paper at EIT, and regularly attends the New Zealand Aged Care Association clinical manager seminars. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The non-executive director performs the general manager’s role if he is temporarily absent. During the temporary absence of the clinical manager, the RN, who has three years’ experience with the organisation, is available. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: A combined quality and risk policy and plan is sighted for the organisation. This includes organisational goals, strategies to embed a consumer focus, managing potential and actual risks, and the provision of safe and effective services. There is a commitment to continuous quality improvement, which is reflected in the business plan, mission statement, organisational objectives, and the quality and risk management system. The quality and risk management system is designed to assess and monitor quality care is being delivered and that continuous quality improvement is at the forefront of staff meetings.   Business and service delivery goals and objectives are measured by established processes, including a detailed and extensive schedule of internal audits. These audits include clinical and household services, health and safety, admission processes, emergency and security systems and food safety (completed audits sighted).A rating system is developed, and there is evidence of appropriate action being taken in response to audit results. Audit results are discussed at the monthly senior management team meeting. This team reviews any corrective actions from the previous month, infection control, adverse events, falls, clinical events, hazards and maintenance register, complaints/suggestions, staffing occupancy, health and safety and food services (meeting minutes sighted). The outcomes of these meetings are communicated to staff at handover meetings, the monthly staff meetings and at the weekly RN meetings. Minutes of all these meetings are available and are sighted. Seven of seven staff interviewed confirm they are kept informed about audit results and any required practice changes.  The hazards register is current and kept updated (interview with general manager and review of records). Chemical safety data sheets are sighted. There is an accident/incident reporting system. The staff orientation programme ensures staff are familiar with all of these processes (ten of ten staff files, and six of six staff interviews), and ongoing education is provided on a regular basis. A range of risk assessment tools are utilised to manage clinical risk (sighted in ten of ten resident files). The clinical manager reviews all the clinical incident forms in the first instance and all reviews are completed in accordance with the processes and timeframes contained in the policy. The senior management team reviews all incidents at its monthly meeting.   Policies and procedures sighted are aligned with current good practice. Clinical policies and procedures are developed in consultation with relevant clinical specialists (such as specialist nurses from the Hawke’s Bay District Health Board), and from information gained from product representatives and attendance at education sessions and updates. When policies/procedures are changed or updated, seven of seven staff confirm they are informed about this changes – via the communication book, meeting minutes and at staff meetings. An external consultant is supporting the organisation to further develop its existing document management systems and processes.  An annual resident/family satisfaction survey is undertaken (records of 2103 survey sighted), with recommendations being actioned from the survey results. There are three formal resident/family meetings held each year (August and December 2013 minutes sighted). Among the items discussed at the August meeting were the resident/family survey results, the complaints process, open disclosure, and an open discussion on things relatives would chose for themselves if going into aged residential care. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: The adverse event reporting policy includes definitions of incidents, open disclosure, accidents, adverse, events, medical error and statutory reporting requirements  All adverse, unplanned or untoward events are systematically documented, investigated and actions taken as required. These are also reviewed by the senior management team at their monthly meetings (minutes sighted). The relatively small size of the organisation (33 beds) means that negative trends are easily identified, and strategies can be put in place to halt or manage these. For example, when an increase in urinary tract infections was identified, an additional fluid round for residents was implemented (confirmed by meeting minutes and communication with clinical manager and RN).  The general and clinical manager demonstrates a good understanding of the statutory and/or regulatory obligations in relation to essential notification reporting. The recent change of clinical manager was reported to the District Health Board and the Ministry of Health (evidence sighted).  A review of three recent incident forms and associated resident records confirm that there is open disclosure with families and all residents and families interviewed express their satisfaction with the timely nature of the information provided to them. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: The service continuum policy notes all staff will be thoroughly reference, police, and where applicable, visa checked prior to being offered a position at Bryant House. ‘Bryant House ensures staff have suitable qualifications and skills to provide a high level of care to our residents.’ Annual performance appraisals and resident surveys are undertaken to ensure that a high care level is maintained and training offered where appropriate.  A comprehensive human resources folder contains employment agreements, detailed orientation programmes for new staff, including checklists to be signed off, job descriptions, task lists, education and training, competency assessment sheets and quizzes, performance appraisals and employee orientation booklet.   The retention of a number of long-term staff is a strength of the organisation, with at least four staff working at Bryant House for between 17-32 years.  Ten staff files were reviewed, including two staff with more than a decade of service. Performance reviews are undertaken on an annual basis (sighted in seven of seven files of staff who have been employed for more than twelve months). Three recent employees have not been employed long enough for planned three-month appraisals to be undertaken, but their files showed evidence of a formal application process, referee and police checks, and current job descriptions. Two recently-employed staff confirm their satisfaction with the orientation provided to them, and that they feel well-prepared for their caregiving roles.   There is a system in place for verifying the professional qualifications of all health professionals who deliver services within the facility. Annual practising certificates are sighted for all these health professionals – four general practitioners, pharmacists, podiatrist and two registered nurses. As required in the vehicle policy and procedure, the diversional therapist and a volunteer who drive the mobility van have undergone driving competency assessments, and copies of their driving licenses are on record (sighted in two of two files). All staff responsible for medication administration have current medication competency completed, and all staff who undertake facility cleaning undergo chemical safety training.   Details of the extensive staff education offered in 2013 is sighted and there are numerous opportunities for staff to maintain/upgrade their knowledge and skills, and cover all the requirements of the ARCD17.8. There is good staff attendance at these sessions. Regular education sessions for caregivers are also held at the Mary Doyle Centre, and include back care, health and safety, falls, pain management. The facility also holds its own monthly in-service programme. Food handling and manual handling sessions were offered in February 2014, and attended by 15 staff (records sighted). Three caregivers and the diversional therapist are undertaking the eight-month ‘Walking in Another’s Shoes’ programme (confirmed by the clinical manager and two of the staff concerned). The Clinical Manager regularly attends the study days provided for RNs by the New Zealand Aged Care Association, and is also enrolled in an on-line dementia course from the University of Tasmania.   There are written records of staff attendance at education sessions, confirmed in three of three staff files sampled. Seven of seven staff interviewed confirm their satisfaction with the educational opportunities provided to them, and feel supported to make the most of these. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: The rationale for service provider levels and skills mixes is outlined in the Organisational Management: service provider availability policy.   The skill mix and staffing ratios (as evidence in a review of four weeks of rosters), exceed contractual requirements.   Two registered nurses are onsite on weekdays (9.30-4pm, 8.30-3pm) and are on call (week about) at all other times, 24 hours a day, seven days a week. Four caregivers are rostered on morning duties (one on seven and a half hour shift, two on five hour shifts, and one on a four hour shift). These shifts also include one hour on cleaning duties. Two caregivers are on duty for eight hours each afternoon and night shift. Night shift staff also undertake some cleaning duties On interview, seven of seven staff confirm their satisfaction with staffing levels.   There is an adequate number of auxiliary staff employed to provide support services (for example, food services staff and activities coordinator). There are 28 hours of dedicated cleaning time, plus the night staff also undertake some cleaning duties. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Stage one: policies note progress notes are to have full date, signature and designation of scribe and to be legible. The frequency of documentation in the clinical record is specified.   Stage two: Entries are made in progress notes by caregivers on at least a shift by shift basis. Records are legible, written in ink and date and signed. The designation of the staff member making the entry is noted. The RN is documenting at least weekly in resident files sampled. This includes a summary of the residents care needs and any change in condition. Entries are also made by the CM or RN sooner if appropriate. There are two areas identified as requiring improvement. These are ensuring resident records are stored in a confidential/secure manner and ensuring documentation related to enduring power of attorney is accurate.  The resident records are integrated with a copy of the needs assessment, admission agreement, consents, advanced directives, family communications, caregiver and RN progress notes, GP notes, laboratory/other investigation results and communications for other health providers including DHB medical specialists are sighted in residents’ files.  ARRC contract requirements met excluding A 15.1. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Stage two: Entries are made in progress notes by caregivers on at least a shift by shift basis. Records are legible, written in ink and date and signed. The designation of the staff member making the entry is noted. The RN is documenting at least weekly in resident files sampled. This includes a summary of the residents care needs and any change in condition over the preceding week. Entries are also made by the CM or RN sooner if appropriate. Documentation sighted includes details of incidents/adverse events, infections, communications with family members and health professionals, participation in activities, completion of activities of daily living and mood/behaviour related issues.   In the front of resident files there is an area used to identify who the preferred contact is. Staff are also documenting whether the resident has enduring power of attorney in place and whether this is for property and finance or care/welfare. The information is in-correct in two of six resident files initially sampled. As an example notes the family member has EPOA for care and financial matters. The copy of the EPOA on file relates only to property. Ensuring documentation related to enduring power of attorney is accurate is an area requiring improvement. The sample size is expanded and the records of four more residents are reviewed. The EPOA information recorded for three residents is congruent with copies of the EPOA on file. The other residents family member advise they have EPOA however documents verifying this have not yet been provided. The RN has contacted the family member and requested a copy of this several weeks prior to audit. This communication/request is documented. |
| **Finding:** |
| In the front of residents’ files there is an area used to identify who the preferred contact is. Staff are also documenting whether the resident has an enduring power of attorney in place and whether this is for property and finance or care/welfare. The information is in-correct in two residents’ files sampled. As an example the residents record notes the family member has EPOA for care and financial matters. The copy of the EPOA on file relates only to property. |
| **Corrective Action:** |
| Ensure records related to EPOA are accurate and copies are available on file where these exist. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Resident files are kept in the ‘nurse’s cupboard’ off a small lounge near the kitchen. This is unlocked and the door sighted open on many occasions during audit. Ensuring residents’ records are kept in a secure manner is an area requiring improvement. |
| **Finding:** |
| Resident information not in current use (archived) is stored securely and privacy of information is maintained. Resident information/files that are in current use are kept in a small office that is left open when unattended. |
| **Corrective Action:** |
| Ensure that all resident information is maintained securely and confidentially. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: the entry policy notes the preadmission / admission process and how Bryant House reviews and manages risks related to the admission process. Residents must be assessed as requiring rest home level care.  Stage two: The service provides rest home level care. The entry criteria, assessment and entry process is clearly documented and communicated to the potential resident and family as confirmed during resident and family interviews. Five of five family members confirm information about Bryant House was explained in a clear manner when they made enquiries and again during the admission process.   Information about the service is available on the internet and in hardcopy. The CM reports having a good working relationship with the local referral agencies who are aware of the services offered. The CM advises when there are no beds available the enquirer will be advised. Records of enquiries are maintained. The CM advised these are reviewed as beds become available and prospective residents and family members contacted to see if they still require access. ARRC requirement are met . |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The declining entry to service policy notes where it has been deemed necessary to decline a referral/entry to Bryant House we will ensure the resident and where appropriate their family/whanau or advocate and/or referral agency are fully informed of the reasons why entry was declined and offer other options or alternative services that may better suit the specific requirements of the resident. An interpreter is to be used if required. A register of reasons for declining a prospective resident will be maintained.  Stage two: The CM and RN interviewed advised patients would only be declined entry if: - the resident is immobile and cannot transfer from bed to chair - there are no beds available - gender related. If the only bed available is a room that shares an ensuite with another resident; the residents’ on both rooms are to be the same gender - if the level of care/service required by the prospective resident cannot be met at Bryant House.  The RN and CM advise in the event a prospective resident is declined entry they would be advised of the rationale and provided with information on other facilities that can be contacted and the Eldernet website. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policy identifies:  -an initial nursing assessment and short term care plan will be developed by a RN within 24 hours of admission. New permanent residents will be seen by the GP within two days and is stable suitable for ongoing review three monthly. Residents are to be seen by the GP if unwell.  - within two weeks of admission the resident will have a Braden scale assessment (predicting pressure sore risk) completed by a registered nurse. This will be reviewed not less than six monthly thereafter or where there is a significant change in need. -within two weeks of admission the resident will have a Coombe Assessment for predicting fall risk completed by a registered nurse. This will be reviewed not less than six monthly thereafter or where there is a significant change in need. - within two weeks of admission all residents who are assessed as having a degree of incontinence will have a continence assessment completed by the registered nurse. - within three weeks of admission the resident will have a social assessment completed by the activities coordinator.  - the resident lifestyle care plan (RLCP) will be developed. This will reflect current best practice and will be coordinated to minimise potentially harmful breaks in service delivery. Cultural and/or spiritual needs will be discussed and documented in the resident’s file - where residents care needs change, the need for and process of obtaining a reassessment is identified.   The policy includes detailing what forms/documentation is to be completed and the other practical components of orientating a new resident to the facility.    Stage two: Each stage of service provision (assessment, planning, and oversight of provision of care, evaluation and review) is undertaken by a RN or CM who is suitably qualified and experienced to perform the role. Both the RN and CM have a current practising certificate (sighted). The main provision of care is provided by caregivers.  The initial assessment covers the resident’s medical condition and current medications, and nursing assessments including (but is not limited to) activity, sleep/rest patterns, exercise/mobility, nutrition/fluid needs, elimination, cognition, relationships/coping, social /recreational, level of independence, skin integrity, hygiene/dressing and values and beliefs are completed.  The care plan format identifies goal/outcome criteria and interventions. Five of six resident file reviews confirm that all timeframes as shown in policy are met. One resident’s RLCP was not developed within 21 days of admission. The RN advised this was not completed within 21 days as the service had been trialling a new care plan which took significantly longer to complete. The service subsequently reverted to the original version of the care plan which still remains in use. The care plan that had not been completed within 21 days was typed and is different to the other plans sampled. The sample size is expanded during audit. Four more resident files reviewed have RLCPs developed within 21 days. This is not raised as an area for improvement as it is the only example of ARRC contractual timeframes not being met. The CM and RN interviewed are able to detail the ARRC contract requirements when asked.  The long term care plan is reviewed at least six monthly or sooner where the resident’s need has changed. The care plan format includes the main medical issues, nutrition, hygiene, skin integrity, exercise/mobility, elimination, sleep/rest patterns, cognitive abilities, relationships/coping, value/belief pattern, and individual daily routine. All residents have an introductory page which identifies the resident’s demographic data, allergies, next of kin and contact details, baseline recordings on admission including weight, blood pressure (BP), pulse, and temperature. The residents ‘resuscitation status is noted. Six of six files reviewed identify that residents are assessed for entry as rest home level care. One resident audited is currently being reassessed for hospital level care.  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Each shift has a verbal handover and there is a written handover sheet which identifies care requirements including any required changes. The observed handover verifies the residents’ care needs are being communicated.  Each shift makes entries into resident progress notes to record care provided and any additional changes that may be required. Care review processes includes the resident and/or family, GP, and nursing staff.  Interviews with four caregivers, one RN, the CM and the GP confirms that they receive appropriate information to ensure all resident cares can be delivered in a manner to meet their identified needs. Staff report they work very well as a team and that they are informed in a timely manner of individual resident needs. During interview, the GP reports that there is very good communication between himself and the CM/RN to ensure continuity and timeliness of care.   Tracer:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service implements policies and procedures to ensure the use of appropriate assessment tools for all residents so that needs are ascertained and monitored. The tools sighted include continence, hygiene and personal grooming, Braden scale (predicting pressure area), falls (Coombes) assessment, pain, social activity, cultural/spiritual/values/beliefs, and behaviour management. The resident’s needs, outcomes and goals are clearly identified during the assessment process and information is used to inform care planning processes. All assessments are in the resident files and accessible to staff. The Braden, Coombes and Continence assessments are repeated at least six monthly in sampled files. All six residents and five family members interviewed confirm the residents needs are being identified and met. The caregivers interviewed confirm they are advised by the RN or CM when residents assessed needs have changed.  ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies and procedures provide guidance for staff on care planning. Resident lifestyle care plans are present in all six residents’ files reviewed during audit. The RLCP’s are reviewed at least six monthly or sooner where required. The residents’ care plans are sufficiently detailed to provide guidance for staff on managing residents’ care needs with the exception of challenging behaviour. This is an area requiring improvement. Short term care plans are used to provide guidance for residents with short term care needs.  ARRC contract requirements are met excluding D13.6 J. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Stage one: The service delivery/interventions policy notes short term care plans (health variance plan) will be developed for care needs which require a specific focus or a timeframe. The policy provides guidance for staff on managing a number of events including (but not limited to) burns, seizures, hyperglycaemias, hypoglycaemia and chest pain.  Stage two: Six of six residents ‘files reviewed identify that long term care planning interventions are individualised to reflect resident’s assessed needs. Care planning is resident focused and includes input from staff involved in resident care, as well as the resident and family as is appropriate. Assessment processes inform care planning in a meaningful manner. Two of two residents with challenging behaviours do not have information documented in their RLCP to detail triggers for anxiety and behaviours and personalised interventions to de-escalate, distract or otherwise manage. Despite this lack of information in the RCLP; the residents are receiving timely and personalised care as interventions have been communicated via other methods including shift handover.  Short term care plans are sighted in relevant resident files for each episode of an infection. There is ongoing evaluation until the infection is confirmed as being resolved. Wound care plans are developed for residents who require wound care, wound/skin assessment or preventative skin care to prevent skin integrity issues. One resident audited has a short term care plan for the pressure area on the sacrum and for conjunctivitis on file.  Residents have one folder of records that contains their medical information, nursing assessments, RLCP, monthly routine observations (including weight), monitoring of bowel activities, activities/ therapies, family meeting summary, and correspondence including off site consultations.  Staff interviews with four caregivers, one RN, the CM and the GP confirm the information ensures continuity of care. Interviews with six of six residents and five of five family members report all care is provided to meet their needs by staff who are skilled and kind to deal with varying situations. |
| **Finding:** |
| There is currently no information included in two resident’s care plans in relation to managing the residents challenging behaviours. Missing from the care plans are the known triggers for these episodes of challenging behaviour, individualised de-escalation /distraction activities and ongoing management. |
| **Corrective Action:** |
| Ensure care plans are sufficiently detailed to guide all aspects of care. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. Six of six care plan reviews confirm care planning is individualised and personalised to cater for each resident’s assessed needs from all services involved. As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions.   An interview with four of four caregivers and the activities coordinator confirms the staff knowledge and experience allows them to follow the instructions shown on residents’ care plans to ensure appropriate care for each resident. If an intervention is not working well it is reported to the RN or CM who evaluates the resident’s progress.   Six of six residents and five of five family members confirm during interview that they are very satisfied with the care and interventions provided by the service. Residents confirm they and/or their family are included in care decisions.  ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The activities policy notes Bryant House has a planned activities programme for residents that meets or exceeds 8 hours per week. Programmes are designed by the activities co-ordinator and/or registered nurse and takes into account the individual resident profiles along with preferences, capability, age, gender, culture, spirituality and educational needs. ach programme includes: - a creative component - an intellectually stimulating component - simple tasks - a group activity(s) - individual activities - social contact outside Bryant House - community involvement   Stage two: The activities coordinator has been employed at Bryant House for over 32 years. She has been in the role of activities coordinator for 20 years. The activities coordinator has undertaken individual assessments of each resident’s interests, likes, dislikes, background and this is linked with the resident’s physical and mental capabilities.  Individual activities plans are developed for each resident and sighted in the residents’ files reviewed. The organisation activity plan is then developed with input from the CM and includes: van trips (two per week), celebrating residents’ birthdays, celebrating special days (e.g. Waitangi day, St Patricks day), exercises, sing-a-longs, church services, art and crafts, bingo, games, quizzes, bowls, news reading, visits by entertainers and canine pets. A range of activities including polishing silver, threading beads, posting boxes, colouring in are available for staff to give residents who are restless and wandering. One resident is sighted carrying a doll. The activities coordinator advised February was a ‘cultural month”. Residents were offered ‘boil up’ on Waitangi Day. Residents remembered the Napier earthquake, and have been out for ‘high tea’. Residents participate in a bowls challenge with another residential care facility.  The facility vehicle transports eight passengers and the driver. The activities coordinator has a current first aid certificate and copy of drivers licence on file as sighted by the second auditor. The activities coordinator advises she completed a corrective action plan when a resident is no longer able to go on outings in the vehicle due to decline in physical ability. The activities coordinator undertakes evaluation of individual resident’s participation in activities on at least a monthly basis. These are sighted in six of six resident files reviewed.   Six of six residents and all five family members interviewed confirm there are a variety of activities available which are enjoyed. Participation in activities is voluntary.  ARRC contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The interventions documented on residents’ lifestyle care plans are evaluated at least six monthly by the RN or CM. There are some examples of sufficiently detailed evaluations. However, evaluations do not always indicate the degree of achievement or response to supports and interventions that are in place. This is an area requiring improvement.  There is evidence that where the resident’s needs have changed and/or if planned interventions are not working well they are changed and staff, the resident and family are informed.   Short term care plans are utilised when residents are identified as having an infection. While wound care plans are developed and wound care is signed as being undertaken. A wound evaluation form is available however is not consistently in use. This is an area requiring improvement.   Where progress is different from expected, the service responds by initiating changes to the care plan as sighted in six of six resident file’s reviews or by use of short term care planning interventions for temporary changes. This is sighted in all applicable files sampled at audit.  Six of six residents and five of five family member interviews confirm services are delivered in a manner that meets all their needs. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The file review of three of three residents’ who have been in the facility more than six months identifies that the interventions documented on residents’ lifestyle care plans are routinely evaluated at least six monthly. Whilst the remaining three residents have been in the facility less than six months some components of the long term care plan have already been evaluated with a full review due at the six months post admission time. There are some examples of sufficiently detailed evaluations. However, evaluations do not always indicate the degree of achievement or response to supports and interventions that are in place. Other examples of the evaluation includes a comment NAD (nothing abnormal detected), satisfactory or commentary that does not include all relevant components (as an example the number of infections the resident has had). This is an area requiring improvement. There is only a very small area in the template for evaluations to be documented in the care plans in use.  There is evidence that where the residents’ needs have changed and/or if planned interventions are not working well they are changed and staff are informed. Resident and family input is shown in documentation sighted including via family meetings (held six monthly or sooner if required) and via the family communication record sheet. The residents care needs are reviewed, discussed with the resident and family members as appropriate.  Short term care plans are utilised when residents are identified as having an infection. There is evidence the effectiveness of treatment/interventions has been evaluated for all infections reported for the six residents. Wound care plans are developed and wound care is being undertaken. A wound evaluation form is available and sighted to be in use for one resident having wound cares completed. However for one patient audited; there is no evaluation of the appearance, size and state of the wound (pressure area) in the records sighted. This is an area requiring improvement.   Where progress is different from expected, the service responds by initiating changes to the care plan as sighted in six of six file reviews or by use of short term care planning interventions for temporary changes. Six of six residents and five of five family member interviews confirm services are delivered in a manner that meets all their needs.  Monthly checks of resident’s weight and vital signs is being undertaken for five of six residents’ files sampled. For the remaining resident these checks are no longer required.  ARCC contract requirements are met excluding D16.4 d |
| **Finding:** |
| Evaluations of residents’ progress in achieving their goals is not consistently evident in the residents’ files sampled. There are some examples of sufficiently detailed evaluations. Other examples include NAD (nothing abnormal detected), satisfactory or commentary that does not include all relevant componants. There is only a small area for evaluations to be documented in the care plans in use.  While wound care plans are developed and wound care is signed as being undertaken; missing is evaluation of the appearance and state of the wound (pressure area) for one resident. |
| **Corrective Action:** |
| Ensure all evaluations of resident progress to achieving goals are sufficiently detailed and include all relevant and current information. Ensure evaluations are documeted that demonstrate the ongoing condition of wounds and progress or otherwise in healing/managing the wound. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document: The referral policy includes a flow chart for referral of residents and includes consultation with the resident and family/whanau. The reason for a referral is to be documented in the resident’s progress notes.   Stage two: Referrals are made to other health care service by the RN/CM or GP as appropriate with resident and or family agreement. One resident has been referred for re-assessment for hospital level of care. The resident and family have been seen by a staff member from the needs assessment service. A gerontology review is awaited. The resident files sampled include residents accessing services to have hearing aids repaired/adjusted. Copies of appointment letters for residents to attend appointments with medical specialists at the DHB outpatient services are sighted both on the notice board and in resident files sighted.  The CM advises residents can be referred to a physiotherapist that has a practice in the community. The podiatrist visits the rest home routinely approximately every six weeks (or sooner for urgent appointments with new residents). There is a referral process for this service.  The five family members interviewed verify they are advised in a timely manner if the resident is unwell or consideration is being given to referring the resident to other health practitioners. The CM is observed phoning a family member during audit to advise them of the date and time a resident is scheduled to attend a medical specialists appointment at the DHB.  The CM reports a very good collaborative relationship with the gerontology nurse specialists at the DHB. Dietitian services can also be accessed via the DHB.   During interview the GP confirms that appropriate referrals to other health and disability services are well managed at the service.   ARRC requirements are met. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The transition, exit, discharge or transfer policy detail the process for arranging the planned discharge, exit or transfer of residents. Includes the information that is to be provided during this and need to ensure any risks are identified and managed and the resident and family/whanau is kept informed.  A template form includes areas for staff to document the resident’s allergies, diagnosis, next of kin (NOK) information, whether advance directives are in place and a summary of the resident’s abilities in relation to activities of daily living.  Stage two: The RN and CM advise patient being transferred to the DHB have relevant health records sent using the ‘yellow envelope’ and the residents next of kin are informed. A resident transfer form is to be completed, a copy of the resident medication chart provided and other relevant information copies including details of next of kin contact details, advance directives, copy of the GP notes and other relevant information. The CM advises the process works well and the ‘yellow envelope’ has a checklist included.  The CM advises where residents are required to transfer to another residential care facility; a copy of the residents’ medication records, allergies, current care plan, advance directives, GP notes/medical history, vital sign chart, activities plan and other information. The CM advises all effort is made to ensure timely information is provided to reduce the stress associated with the process as much as possible. The CM can identify the process required where a resident transfers to a residential care facility outside the DHB region.  One resident and family member interviewed advised the resident is relocating to another facility shortly to enable to resident to be with a spouse. The resident advises ‘not wanting to go as staff are fabulous’ and ‘Bryant House is ‘home’. However, due to the spouses change in health status the move will be undertaken. The resident advises staff and management have been fantastic at helping facilitate the transfer processes. The resident has been assured that if in the future the resident wishes to return to the rest home this will be readily facilitated.  ARCC Contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management policy details the requirements for prescribing, ordering, and receiving, storing, administering and documenting medication administration.   The medication records of thirteen residents are reviewed at audit. These are clearly documented and each entry individually signed by the prescriber. Medication reconciliation is occurring. Medications are sighted to be given as prescribed.   Medication management practices sighted at audit meet current accepted practice with the exception of two areas. Eye drops and nasal spray medication is not sufficiently secured and the updating of standing orders to align with current required practice has commenced but not yet completed.  Thirteen caregivers are competent to administer records. Competency assessments are undertaken on an annual basis and records sighted. The RN has completed syringe driver competency via the Hospice services. The CM is scheduled to attend the next training.  There are currently no resident self-administering any medications. The RN can detail the processes of what checks would be undertaken prior to self-administration of medication would occur.  All medications checked at random are within expiry date. Bottles of eye drops are sighted dated when opened. The RNs undertakes weekly counts of the balance of controlled medications (CDs). Each entry in the CD register is legible and signed by two staff. A six monthly quantity stock count was undertaken by the pharmacist on 23 January 2014.   Five of five family members interviewed verify they are informed by the RN or CM of all new medications commenced (and the rationale); and when medications are stopped or the dose changed. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Document review: The medication management policy details the requirements for prescribing, ordering, and receiving, storing, administering and documenting medication administration. The process for managing control medication is noted and includes the RN undertaking a weekly check. The policy includes allergies are required to be assessed and documented. Photographs are used to aid identifying residents. Obsolete or expired medications are to be returned to pharmacy.  The policy notes that residents may self-administer their medications. The GP is required to have assessed and documented the resident is competent to do so at least every three months. Medication is to be stored securely. The process for the RN to check the resident is taking the medication is noted. Medication variances/errors are to be reported to the RN/manager.  Stage two: the medication records of thirteen residents reviewed at audit. The records are written in ink. Allergies have been documented as being assessed. Twelve of thirteen medication charts have been signed as reviewed by the GP in the preceding three months. For the remaining medication chart the GP had undertaken a three monthly medication review in the commentary of his visit notes. This is an exception as discussed with the RN, CM and GP who advise it is normal practice to document these reviews on the medication chart. Entries have been made by either the general practitioner or transcribed by the pharmacist as a component of medication reconciliation. Every entry is then checked and individually signed by the prescriber in the sampled files prior to being made available for staff. Medication is ordered from pharmacy In one month quantities; this comprises two week packs; or sooner where changes have been made. If an additional medication is added, a supplementary pack is provided by pharmacy with only the new medication contained. If medications are removed from use; pharmacy are requested to provide all the contents of the new pack again. The old pack is placed in a container to be returned to pharmacy for disposal.   There are implemented processes to check off pharmacy deliveries against the orders as well as checking the medication provider against the written records. Medication reconciliation is occurring when residents’ enter or facility including when returning from the hospital or specialist appointments.  Medications are sighted to be given as prescribed. A master signature list is maintained for each patient.   A medication round is observed. The RN reviews the medication record against the content of the blister pack; identifies the resident (a photograph is present on each residents medication records and a notation as to when the photograph is obtained); administers the medications with explanations of reason/intended use; observes the medication being taken; then signs the administration record.  Where medications are refused or withheld, this is noted.   Medication standing orders are available. These are in the process of being updated to reflect the new requirements of the national standing order framework. A copy of the revised draft document sighted and the further changes being undertaken were discussed with the CM. The document will then be provided to the GPs for review. Ensuring the standing orders are sufficiently detailed, reviewed and signed annually by prescribers is an area for improvement.  All medications checked at random are within expiry date. Bottles of eye drops are sighted dated when opened.   All oral and controlled mediations are secured in locked cupboards/drawers. Eye drops and nasal sprays are stored in a box on top of the medication trolley which is not secured. The door of the room where this medication trolley is stored is also not locked and sighted open throughout the audit. Staff advise there are a couple of residents who are ‘wanderers’ however they do not typically go into this area. Ensuring all medications are appropriately secure is an area requiring improvement.  Five of five family members interviewed verify they are informed by the RN or CM of all new medications commenced (and the rationale); and when medications are stopped or the dose changed. |
| **Finding:** |
| The medication standing order has been recently revised to align with the new national standing order requirements. These have not yet been signed by the prescribers. The current standing orders (using the old format) were last reviewed and signed by the general practitioners in December 2012.  Nasal sprays and eye drops are being stored on the top of the medication trolley in the nurses’ cupboard which is unlocked. |
| **Corrective Action:** |
| Make the final amendments to the new draft medication standing orders and obtain prescribers review and sign off. Ensure all medications are stored securely. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Policies detail the process for identifying and communicating individual resident diet preferences, dislike and allergies. The process for monitoring resident weights is noted and recommended interventions for weight loss are summarised.  The policies for food management and kitchen services sighted and includes process for ordering, storage of food and need to monitor temperatures.  Stage two: The current four weekly rotating menu and is planned for review as detailed in emails sighted between the owner and a consultant dietitian. It was last reviewed in September 2010 by a registered dietitian. The cook confirms that the food and fluid needs of residents are all met by the service. Examples sighted include one resident audited that has a food allergy, another resident requires a diabetic diet and other residents who have having a nutritional supplement provided. The service celebrates birthdays and cultural festivals with appropriate additions to menus.   Interviews with six of six residents and five of five family members confirm they are very happy with the food service and that their likes and dislikes are catered for.   There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are meet current legislation and guidelines. Kitchen staff have completed food safety qualifications.   ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The management of waste and hazardous substances policy details how staff are to dispose of healthcare waste including controlled waste, sharps, chemicals, non-hazardous waste and general waste, and compliance with this policy is observed. Staff are required to report any exposures to waste and hazardous substances via the incident reporting systems. Current material safety data sheets are prominently displayed for all chemicals used on site. All cleaning products that have been decanted into smaller containers are appropriately and adequately labelled. The policy notes when changing chemicals staff must use safety equipment such as: gloves, apron and face mask/shield (equipment sighted). All staff engaged in the handling of chemicals have received chemical safety training (records sighted, and confirmed by clinical manager and household manager).   Policies on the management of blood and body fluid spills, infectious materials and needle stick injuries are included in the infection control manuals.   The facility has a contract with Hawke’s Bay Planned Maintenance (HBPM) who are responsible for fire safety assessment and testing of fire related equipment such as hose reels and fire extinguishers (records sighted).The current control panel is shortly to be replaced with an apartment panel which will enable non-brigade calling smoke detectors to be used throughout the facility. The general manager is currently negotiating with HBPM in relation to a planned maintenance proposal and service agreement  On interview, seven of seven staff report that there are appropriate and suitable supplies of personal protective equipment, such as disposable gloves and aprons, available for their use. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Bryant House offers its residents a comfortable and homely living environment. There is a detailed schedule for cleaning resident rooms, which were observed to be personalised, well-maintained and clean. All resident rooms undergo a spring clean every four to six weeks, and all rooms are thoroughly reviewed, and if necessary, updated when a resident moves out.  There are a number of pleasant outside areas for residents to enjoy, and residents were observed to be making full use of these, including the tables and chairs situated on the front lawn area. Two resident lounges, and three separate dining areas, also contribute to the homely nature of the facility. One outdoor area for smokers meets legislative requirements. Mobility equipment, such as wheelchairs, are well maintained. There is easy access to the building through a number of entry points, and residents are able to move freely around the building, and to the numerous outside areas.   The building has a current warrant of fitness (issued 15 October 2013, expires 1 November 2014). The facility van has a current registration and warrant of fitness.  The scheduled testing of electrical and clinical equipment, the maintenance of toilets and showers, and the cleaning of bathrooms are identified as areas for improvement. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The facility is generally well maintained and complies with legislative requirements, except for electrical testing, the calibration of clinical equipment and the maintenance of bathroom fittings and equipment.  Although there is a policy on the testing of electrical equipment, there is no schedule for regular testing of equipment, and other than informal review by the general manager, general electrical equipment (such as televisions and microwaves)is not tested. There is currently no calibration of clinical equipment, or schedule to ensure this is undertaken.  There are adequate numbers of toilets/showers and bathing facilities in the facility, there is no planned maintenance schedule to ensure that these, or equipment such as shower chairs, are maintained appropriately. Minor repair work is required to maintain impervious surfaces, and to facilitate thorough cleaning.  In several of the bathrooms, small areas of mould and/or inadequate cleaning is identified. |
| **Finding:** |
| Electrical equipment is not regularly tested, and a schedule for testing has yet to be developed  Clinical equipment, such as blood pressure monitors and weighing scales do not currently have performance monitoring checks completed. There is no planned maintenance schedule to ensure that toilet/showers and bathing areas in the facility, or equipment such as shower chairs, are maintained appropriately. Minor repair work is required to maintain impervious surfaces, and to facilitate thorough cleaning. |
| **Corrective Action:** |
| A schedule is developed and implemented to ensure that all electrical equipment is regularly tested, and medical equipment has performance monitoring checks completed. Address all outstanding maintenance issues, and develop a planned maintenance schedule for the future. Ensure that the facility cleaning schedule includes all required cleaning in the bathroom/toilets areas, and this is monitored. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The rest home has adequate toileting and showering facilities for its 33 residents’ rooms.   There are six residents’ rooms where an ensuite toilet and hand basin is shared between two rooms. In each of the three ‘avenues’ of the facility there are two separate showers and two separate toilets for use by residents who do not have an ensuite.  The bathrooms and toilets have appropriate systems to ensure privacy of use. Hot water tempering valves are used to maintain safe water temperatures in resident areas throughout the facility. Water temperatures are monitored monthly (and more frequently if an issue is identified) – records for the past year are sighted. In two instances water temperature in the resident areas has risen above 45 degrees Celsius, and in both instances there is evidence of prompt and appropriate action being taken to remedy this. Informal testing during the audit visit confirms that the water temperature in the resident rooms is at an appropriate temperature.  The sighted hot water temperatures for the kitchen areas are consistently maintained above 60 degrees Celsius. All residents and families interviewed express their satisfaction with the toilet and showering facilities, and the maintenance of their privacy. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bryant House provides 33 resident rooms. At present these are all single occupancy, but several rooms are large enough to accommodate couples should this be required. Visual inspection demonstrates that there is adequate space in all rooms to accommodate the resident, their personal items and mobility aids. Resident rooms are personalised and well maintained. Hospital beds are provided, but residents may bring in their own bed if they so wish. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bryant House provides residents with two lounge areas, and three separate dining areas. One of the lounge areas is large enough to accommodate all residents for special events, such as Christmas parties. All bedrooms are large enough for the residents to entertain visitors in their rooms. In addition, there are a number of areas, such as outdoor seating areas, and verandas which residents and their visitors can use.   The outdoor areas include a smoking area that meets legislative requirements, an enclosed courtyard, and a large front lawn area complete with a number of tables, chairs and sun umbrellas. During the audit visit residents were observed to be making full of the outside areas.   In the three dining areas a number of residents are noted to remain talking together after their meal is completed. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Document review: The cleaning and laundry service policy details how linen is to be collected and managed. The policy includes staff task lists and machinery operating instructions. The policy also includes task list for cleaning staff and summary of products used.   There are designated laundry staff employed for an adequate number of hours seven days each week. The household coordinator, who has been in this role for 22 of her 30 years at Bryant House, demonstrates that safe and effective laundry services are provided. On inspection, the laundry has a dirty to clean flow, with industrial washing and drying equipment. Laundry services are monitored for effectiveness by environmental audits, and monthly service reports from the chemical supplier. There have been no significant incidents with cleaning or laundry services.   On the first day of audit, several small containers of cleaning materials were observed on an open shelf in the laundry. The main chemical storage shed was also noted to be unlocked for some hours during the day (although a stiff bolt made the door difficult to open). Cleaning materials on the three housekeeping carts were either securely locked, or under the constant observation of staff when in use.   The general manager and household manager reviewed the processes around the storage of chemicals, so that all containers of cleaning materials are now securely stored (locked cupboards in the laundry, main chemical storage area is padlocked and can only be accessed by the household manager - confirmed during three separate observations during the second day of the audit).  Six of six residents and five of five family members interviewed confirm the facility is always clean and tidy and resident laundry is washed and returned in a timely manner. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Document review: The essential emergency and security systems policy notes the resident’s GP should be contacted for medical emergencies during working hours. After hours City medical is to be contacted. The policy notes guidance for managing general emergencies including fire, civil defence, staff injury or change in the condition of a resident that causes concern. Emergencies also include fire, earthquake, volcanic eruption, flood, bomb threat, chemical spill or explosion, an aggressive colleague or member of the public, or a medical emergency, this list is not intended to be exhaustive. Copies of the emergency plan are required to be kept in highly visible places around the facility and locatable quickly in an emergency including: the evacuation plan, emergency contacts and a list of emergency wardens or coordinators (confirmed during site visit).   Bryant House has well-developed contingency plans to respond to a range of potential emergencies. A well-equipped civil defence kit (kept in a large plastic ‘wheelie bin’ is kept in the separate garage on the facility grounds (sighted) which includes torches and batteries, and a range of civil defence equipment and information, such as the location of the civil defence headquarters). Civil defence and evacuation information is prominently displayed at the facility entrance, and in several other locations around the facility.   A range of strategies have been implemented to ensure that the service is able to respond appropriately in the event of an emergency. Emergency lighting is available that will last for two hours (checked monthly by external subcontractors to the HBPM service). Arrangements are in place to secure a generator if the power supply is interrupted for more than two hours. Large water storage tanks on the facility roof will meet resident requirements for a minimum of three to four days, including for limited toilet usage. Supplies of food for several days are also secured, and checked regularly. Cooking could be undertaken on the gas BBQ. Residents could be kept warm with additional clothing or extra blankets if required.   Emergency equipment is checked every six months (verified with general manager). Fire extinguishing equipment includes two hose reels, two dry powder extinguishers, two nine-litre water extinguishers, and one fire blanket.  On interview seven of seven staff confirm their understanding of processes to be followed during an emergency or security situation, including evacuation processes.  Caregivers are responsible for checking that all doors and windows in the facility are closed and therefore secure by dusk each night. Evening and night staff check security for each of the three wings (avenues). Caregivers are to ensure the front door is locked no later than 5.30pm in the winter and 8.30pm in the summer or at dusk. On interview, one of one night staff members confirms she feels safe when working at night time.   A recently-installed electronic security gate at the entrance to the property provides additional security and reassurance to residents. There is a side entranceway next to the main gate that is easily opened by residents, and during the audit visits residents were observed to be moving freely in and out of the grounds.   All residents have an individual call-bell in their room to summon assistance if required. These are well-maintained and on testing during the audit visit were found to be in good working order and promptly answered by staff.   A review of three weeks of staffing rosters reveals four separate shifts when there is not a staff member with a current first aid certificate on duty. This identified as an area for improvement.   Six of six residents’ and five of five family confirm call bells are answered in a timely manner. The residents advise they feel ‘safe’. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A review of three weeks of staff rosters identifies there were four separate shifts when no staff member with a current first aid certificate was on duty. |
| **Finding:** |
| There is not a staff member with a current first aid certificate on duty at all times. |
| **Corrective Action:** |
| Ensure there is a staff member with a current first aid certificate on duty at all times |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All residents’ rooms at Bryant House have natural light, are well ventilated, with heating provided by individual eco wall panel heaters. All bedrooms have external opening windows, and a number of rooms have doors that open out onto the internal courtyards or verandas. A number of large heat pumps provide heating or air conditioning for the communal areas of the facility. There is a designated semi enclosed area for residents (and staff) to smoke.   During the audit visit, at a time when the outside temperature was high, the facility was maintained at a comfortable temperature through natural ventilation.   All of the five relatives and six residents interviewed expressed satisfaction with the environment. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bryant House has a ‘no restraint’ policy, and the clinical manger and general manager report restraint has not been used at the facility in the past six years. This is identified as a strength of the service. There are currently no residents who require enablers.   Bryant House has well-developed systems and processes in place should a resident require restraint or enablers. Detailed and comprehensive policy and procedures are available to guide every step of the restraint/enabler process, minimise the use of restraint, and ensure that if restraint was used resident safety would be maintained (document review). Staff receive appropriate training in the safe use of restraint/enablers and ongoing training at least every two years (sighted in training records).  Current approved restraints and enablers are Roxburgh Chair (includes shower/bathing furniture) and seat/lap belts. Bed rails are not used at the facility. |

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

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

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

## **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

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| --- |
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| Restraints are not currently being used, but there are well developed restraint approval process and forms available should restraint be required. This includes clear lines of accountability for restraint use, with the clinical manager having overall responsibility for restraint practice. |

##### **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.

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

#### Standard 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| Well developed and detailed processes are in place should a resident need assessing for possible restraint use. |

##### **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.

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

#### Standard 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| Well developed and detailed documentation is available to ensure that restraints, if required at a future date, would be used safely. |

##### **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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are no episodes of restraint to evaluate, but well developed and detailed processes are in place to ensure that restraint, if used, would be appropriately evaluated. |

##### **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.

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: The infection control programme (December 2013) notes Bryant House has adapted the Bug Control NZ Limited’s Infection Prevention and Control Manual to assist in the implementation of optimum Infection Control Standards. Bryant House will ensure that all personnel have an understanding of how infection is spread by way of orientation, education and training and the focus is on prevention. The infection control programme is to be reviewed annually. The infection prevention and control nurse is to attend two monthly Infection Control Committee (ICC) meetings at the DHB hospital. Bryant House will also implement measures to monitor and control the transmission of infections within the facility- data is to be analysed monthly. An infection prevention focus is required.  Stage two: The RN reports to the CM on infection prevention and control issues. The owner confirms being advised in a timely manner of any concerns. The owner is able to articulate the interventions required if an outbreak is suspected.   The infection control programme is sighted and has been reviewed in December 2013 and is appropriate to the service setting. Staff and residents are offered an annual influenza vaccination. Two residents refused in 2013 and the 2014 programme is underway. The staff influenza vaccinations are reported to be funded by rest home. The RN advises the majority of staff are noted as being vaccinated in 2013. The staff vaccination programme has not yet commenced in 2014.  Hand gel is available at the front entrance of the facility and is located throughout the facility. Staff and visitors are sighted to be using this during audit.  There is a sign detailing symptoms of influenza and ways to reduce the spread. Appropriate personal protective equipment is available in the facility.  Newsletters are provided to residents and family members. The November 2013 newsletter asks family members to avoid coming on site if they are sick to protect the residents. The newsletter notes family members are welcome to phone the facility and staff will ensure the resident is aware of why their family member is not visiting.  The ARRC contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The CM and RN share the responsibilities of infection prevention and control activities. The CM undertakes the audits and provides training/education to staff during orientation and as a component of the ongoing education programme. The RN undertakes the infection surveillance programme and analysis. The RN and CM both initiate transmission based precautions where these are identified as required.  The RN and CM advise advice and support would be obtained from the GP, laboratory, the gerontology nurse specialist or infection prevention and control nurse specialist at the DHB where required. Support would also be sought from the public health service where required.  The RN advises there is yearly study day at the HBDHB - The RN and CNM have attended and certificates of attendance are sighted. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection prevention and control manual which has been developed by an external infection prevention and control consultant. The policy manual is dated as 2014 and includes all policies required to meet this standard. Policies are referenced and comply with current good practice and legislative requirements.  The copy of the manual is available for staff in the ‘nurses’ cupboard’ and this is sighted.  ARRC contract requirements are met. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The RN advises there is yearly study day at HBDHB - The RN and CNM have attended and certificate of attendance sighted.  There are also two monthly in-service presentations at the DHB on topics including wound care, laboratory services, outbreak management, and food safety. The RN advises she attends most of these meetings and the CM also attends. The forums give an opportunity for facilities to discuss IC issues. Minutes of the meeting are maintained. Emails sighted containing invitations for the CM and RN to attend and scheduled topics are listed. Meeting minutes, education/conference summaries and other points to notes are summarised and emailed to attendees. These emails are also sighted.  The CM provides the staff training. Infection prevention and control training is included in the orientation for all new staff and records sighted. Fifteen staff are sighted to have attended the in-service on infection prevention and control in 2013; nine staff attended a skin management in-service; twenty staff attended an in-service on skin tear and skin care; and two staff have attended training on respiratory care.  Four of four caregivers interviewed, the activities co-ordinator and the cook confirm that training on infection prevention and control topics is provided and the content is relevant to their roles and responsibility. All staff working in the kitchen have completed appropriate food safety training and records sighted.  Training is provided to residents on hand hygiene, the influenza vaccination and infection prevention activities where infections are identified. Influenza vaccination consent forms are sighted in resident files (or verbal consent is noted as having being obtained).  ARRC contract 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.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Infection prevention and control policies note: - all infections will be documented on an infection notification form by the senior staff on duty. This data shall be collected not less than weekly and shall be analysed not less than monthly.  - the quality and risk team shall meet not less than monthly to discuss/analyse infection rate audit results (collated monthly) and formulate any corrective action that may be deemed appropriate to reduce the incidence of infections. - a record will be kept of the review, outcome and corrective actions taken and outcomes. - results, findings, conclusions and recommendations will be communicated back to the appropriate clinical staff, management and support staff. - an infection control surveillance report shall be made not less than annually by the CM (or delegated to the RN).  - the surveillance programme shall include but may not be limited to: lower respiratory tract infections, skin and soft tissue infections (e.g. cellulitis, infected pressure sores), influenza, urinary tract infections (UTIs) and eye infections.  Stage two. Surveillance for residents with infections is occurring. Two of two caregivers interviewed advise they are responsible for advising the RN or CM if they are concerned a resident has an infection. The staff are able to identify the common signs and symptoms of infections. The RN confirms during interview staff identify quickly the early signs of infection to enable prompt management.  A review of the infection surveillance data for 2013 and January 2014 identifies the four infections selected from the six resident files sampled are included in the surveillance data and monthly analysis. As part of a strategy to reduce UTI (urinary tract infection) rates an extra fluid round was introduced in early March 2014. Since this was introduced no residents have been identified as having a UTI. The RN advises if a UTI is suspected, a midstream urine (MSU) sample is obtained and a urinalysis conducted. The results (where positive) are communicated to the GP and treatment discussed/implemented as prescribed. The MSU is not sent to the laboratory for culture unless requested this be done by the GP. Short term care plans are present in applicable files sighted.  Two of two caregivers interviewed confirm they are advised of residents with infections by the RN/CM when they are identified. This information is communicated via handover. The staff advise they are informed of surveillance results via staff meetings and can identify the names of residents who are prone to developing infections.  The most common category of infection in 2013 is urinary tract infection. |

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

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

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

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

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

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