# Gwynn Holdings Limited

## Current Status: 11 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

Rata Park rest home is owned and operated by two registered nurses – one providing nurse management of the home. Rata Park provides rest home level care for up to 20 residents with 12 residents accommodated on the day of audit. The owners have owned Rata Park for three years. The service has a quality management system, which requires further implementation. Quality activities are conducted to identify improvements to care and services with further improvements required. Family and residents interviewed all spoke very positively about the care and support provided.

Improvements are required in relation to completion of admission agreements, maintaining a complaints register, aspects of the quality programme, ensuring incident reports are completed, reporting of essential notification, human resource management, aspects of assessments, care plans and interventions, medication management, food service, hot water temperature monitoring and equipment checks, and infection prevention and control.

## Audit Summary as at 11 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 11 March 2014

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

### Organisational Management as at 11 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 11 March 2014

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

### Safe and Appropriate Environment as at 11 March 2014

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

### Restraint Minimisation and Safe Practice as at 11 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 11 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. |  | Some standards applicable to this service partially attained and of low risk. |

## Audit Results as at 11 March 2014

### Consumer Rights

The support provided to residents at Rata Park rest home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Discussions with families identified that they are fully informed of changes in health status and this is recorded. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent and advanced directives are appropriately documented. Staff interviews confirm staff have understanding of informed consent processes. Residents state they have been made aware of and understand the informed consent processes and that appropriate information is provided. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner. Improvements are required whereby admission agreements are completed and the complaints register is maintained.

### Organisational Management

Rata Park rest home has an organisational philosophy, a vision, mission statement and strategic objectives in place. Rata Park is owned and operated by a husband and wife team (both registered nurses) and provide rest home level care for up to 20 residents. A quality management system is in place with further implementation required to ensure all quality activities generates improvements in service. The day-to-day running of the home is provided by one owner with support from one other registered nurse. The facility is guided by a set of policies and procedures. An internal audit programme monitors service performance; audits are conducted as per schedule with corrective actions requiring further implementation and completion. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are recorded as part of incident and accident management. Improvements are required whereby all incident reports are completed and essential notification occurs where required. Human resources processes will be managed in accordance with good employment practice in order to meet legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Improvements are required whereby all aspects of training calendar are completed and annual appraisals are conducted for all employees. Staffing levels are safe and appropriate.

### Continuum of Service Delivery

Rata Park rest home has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into assessment, care planning and care review and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.

There are areas requiring improvement around service delivery timeframes, completion and review of risk assessments, care plan interventions and the use of short-term care plans.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management.

There are areas requiring improvement around the medication system to comply with legislation, protocols and guidelines, staff competencies for insulin administration and monitoring resident’s self- administration of medicines and current competency assessment for residents who self-administer medicines.

Rata Park rest home has a central kitchen and on site staff that provide the food service. Staff have completed food safety training. There was positive feedback from residents about the food service.

There are areas requiring improvement around residents’ dietary profiles and monitoring of freezer temperatures.

### Safe and Appropriate Environment

The facility has a current building warrant of fitness.

There are an adequate number of communal toilet and shower facilities. Residents' rooms are large enough to allow for the safe use of mobility aids, equipment, as well as a staff member.

All laundry is washed on site and cleaning and laundry systems include appropriate monitoring to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There is safe storage of chemicals and equipment, and protective equipment and clothing is provided and is used by staff. The service has implemented policies and procedures for civil defence and other emergencies. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly trial evacuations occur. Emergency lighting, gas heating, and BBQ are available in the event of a power failure. A battery backup supplies power to the emergency lighting a call system. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

There are areas requiring improvement around hot water temperatures, electrical checks and calibration of medical equipment.

### Restraint Minimisation and Safe Practice

The service has policies and procedures, which align with the required standards. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education.

### Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Improvement is required whereby the infection control programme is reviewed annually and best practice infection prevention practices are adhered to. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the on-going in-service education programme. Improvement is required whereby the infection control nurse undertakes annual infection control training. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

# 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:** | Gwynn Holdings Limited |
| **Certificate name:** | Gwynn Holdings Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Rata Park Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 11 March 2014 | **End date:** | 11 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:** | 12 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 13 | Total audit hours | 29 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 5 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 16 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

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

Dated Monday, 31 March 2014

## Executive Summary of Audit

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| **General Overview** |
| Rata Park rest home is owned and operated by two registered nurses – one providing nurse management of the home. Rata Park provides rest home level care for up to 20 residents with 12 residents accommodated on the day of audit. The owners have owned Rata Park for three years. A new graduate registered nurse also works at Rata Park and provides support to the owner operators. The service has a quality management system, which requires further implementation. Quality activities are conducted to identify improvements to care and services with further improvements required. Family and residents interviewed all spoke very positively about the care and support provided. Improvements are required in relation to completion of admission agreements, maintaining a complaints register, aspects of the quality programme, ensuring incident reports are completed, reporting of essential notification, human resource management, aspects of assessments, care plans and interventions, medication management, food service, hot water temperature monitoring and equipment checks, and infection prevention and control. |

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| **Outcome 1.1: Consumer Rights** |
| The support provided to residents at Rata Park rest home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Discussions with families identified that they are fully informed of changes in health status and this is recorded. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent and advanced directives are appropriately documented. Staff interviews confirm staff have understanding of informed consent processes. Residents state they have been made aware of and understand the informed consent processes and that appropriate information is provided. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner. Improvements are required whereby admission agreements are completed and the complaints register is maintained. |

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| **Outcome 1.2: Organisational Management** |
| Rata Park rest home has an organisational philosophy, a vision, mission statement and strategic objectives in place. Rata Park is owned and operated by a husband and wife team (both registered nurses) and provide rest home level care for up to 20 residents. A quality management system is in place with further implementation required to ensure all quality activities generates improvements in service. The day-to-day running of the home is provided by one owner with support from one other registered nurse. The facility is guided by a set of policies and procedures. An internal audit programme monitors service performance; audits are conducted as per schedule with corrective actions requiring further implementation and completion. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are recorded as part of incident and accident management. Improvements are required whereby all incident reports are completed and essential notification occurs where required. Human resources processes will be managed in accordance with good employment practice in order to meet legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Improvements are required whereby all aspects of training calendar are completed and annual appraisals are conducted for all employees. Staffing levels are safe and appropriate. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Rata Park rest home has a documented entry criteria, which is communicated to residents, family and referral agencies.  Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into assessment, care planning and care review and access to a typical range of life experiences and choices. Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. There are areas requiring improvement around service delivery timeframes, completion and review of risk assessments, care plan interventions and the use of short-term care plans.  Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.   There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management.  There are areas requiring improvement around the medication system to comply with legislation, protocols and guidelines, staff competencies for insulin administration and monitoring resident’s self- administration of medicines and current competency assessment for residents who self-administer medicines.  Rata Park rest home has a central kitchen and on site staff that provide the food service. Staff have completed food safety training. There was positive feedback from residents about the food service.  There are areas requiring improvement around residents’ dietary profiles and monitoring of freezer temperatures. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has a current building warrant of fitness. There is an adequate number of communal toilet and shower facilities. Residents' rooms are large enough to allow for the safe use of mobility aids, equipment, as well as a staff member.  All laundry is washed on site and cleaning and laundry systems include appropriate monitoring to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There is safe storage of chemicals and equipment, and protective equipment and clothing is provided and is used by staff. The service has implemented policies and procedures for civil defence and other emergencies. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly trial evacuations occur. Emergency lighting, gas heating, and BBQ are available in the event of a power failure. A battery backup supplies power to the emergency lighting a call system. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas. There are areas requiring improvement around hot water temperatures, electrical checks and calibration of medical equipment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has policies and procedures, which align with the required standards. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Improvement is required whereby the infection control programme is reviewed annually and best practice infection prevention practices are adhered to. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the on-going in-service education programme. Improvement is required whereby the infection control nurse undertakes annual infection control training. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. |

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 31 | 0 | 9 | 5 | 0 | 0 |
| **Criteria** | 0 | 75 | 0 | 11 | 7 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Admission agreement for Rata Park has been recently reviewed and updated to reflect contractual requirements; however, in four of five resident files reviewed, admission agreements were not evident. | Ensure all residents have a signed admission agreement in place. | 60 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Complaints register has not been maintained. Three of four complaints received in 2013 were not recorded on the register. | Maintain an up to date complaints register to record progress and resolution of each complaint. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective actions are not evidenced as implemented or signed off following quality activities | Ensure that all corrective actions developed are implemented and signed off when completed. | 90 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | A resident who has been assessed as requiring hospital level care has remained at Rata Park since March 2012. No evidence of notification to relevant authorities has been provided. Advised by a DHB manager, that they were not aware that a resident was living at Rata Park who required hospital level care | Ensure HealthCert and DHB have given approval for the hospital level resident to remain in rest home level care | 30 |
| HDS(C)S.2008 | Criterion 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. | PA Low | A sample of incident reports reviewed for January and February 2014 evidence that nine of 16 forms are incomplete with investigations, prevention measures and sign off not recorded. | Ensure all incident report forms record investigations conducted, opportunities for improvement in service delivery identified and forms signed off when completed. | 60 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | a) Annual staff appraisals not conducted for three of four staff files reviewed; b) training not provided in the past two years includes elder abuse and neglect, sexuality and intimacy, infection control and continence. | a) Ensure that annual performance appraisals are conducted for all employees; b) provide evidence that all training requirements have been provided for staff. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | i) Initial assessments are not completed on admission in four of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of initial assessments. ii) Initial care plans are not completed on admission in three of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of initial care plans. iii) There is no recorded evidence of GP exemption forms in five of five files reviewed. iv) Two of five files evidence GP clinical reviews are not conducted three monthly. v) GP initial assessments are not conducted as per required timeframes in two of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of GP initial assessments. vi) Weight monitoring is not occurring monthly in three of five files reviewed. One hospital resident has not been weight since January 2012 due to the facility not having sit on scales. vii) Two of five long term care plans do not evidence six monthly evaluations are occurring. | Provide evidence timeframes are adhered to | 90 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Risk assessments are not consistently conducted or reviewed, as required.  i) Rest home resident admitted in September 2013 has no recorded evidence of risk assessments on file.  ii) Hospital resident’s risk assessments were last reviewed in June 2013 and there is no recorded evidence of a dietary profile on file.  iii) Rest home resident admitted in 2012 had risk assessments last reviewed in March 2013. There is no recorded evidence of a continence assessment or a dietary profile on file. iv) Rest home resident admitted in June 2013, had risk assessments completed on admission, however review has not occurred since then. There is no recorded evidence of a dietary profile on file and the pain risk assessment is not dated. v) Rest home resident admitted in March 2013 has completed risk assessments (excluding dietary profile and behavioural assessment) on admission, however no review has occurred since then. | Provide evidence risk assessments are conducted on admission and reviewed regularly. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Interventions are not consistently reflected in long-term care plans.  i) Resident admitted in September 2013 has a history of pain, which is not recorded on the long-term care plan. ii) Resident requiring assessment and treatment at DHB in February 2014 has no recorded evidence of the treatment plan recorded on the long-term care plan. iii) Two residents with challenging behaviours do not have this recorded on their long-term care plans. iv) One hospital level care resident is residing in the facility. The resident was admitted in 2008 for rest home level of care and their condition deteriorated in 2012. NASC reassessment was conducted in March 2012. A letter dated 27/3/12 records the NASC reassessment for hospital level of care and that family requested that the resident remains at the facility as long as possible. Admission agreement was sighted to be signed in 2008. | Provide evidence interventions are recorded on care plans and only rest home level of care residents reside at the facility, as the facility is providing rest home category of services only.` | 90 |
| 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 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Short term care plans are not consistently recorded and completed for short term problems. i) A resident sustained a fall outside of facility in January 2014. This event is recorded in resident’s progress notes and on an incident form. The injuries sustained (skin tears) are not recorded on a short term care plan, or entered onto the long term care plan or recorded on a wound assessment and treatment form. ii) There is evidence of a short term care plan (June 2013) for a short term problem for the hospital resident, however this is not signed of as resolved. iii) Resident requiring investigation/preparation at DHB in December 2013 and February 2014 has no recorded evidence of this as a short term problem. | Provide evidence of the use and completion of short term care plans. | 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 | i) Controlled drug register does not evidence weekly checks are conducted. ii) Two of 12 medication charts do not evidence three monthly reviews. iii) Residents' medicine charts do not list all medications a resident is taking. The pharmacy generates a new medication chart each time a new medicine is added or altered by the GP. The GP states the new medication chart loses PRN medication or any other non-packaged medication off the medicine chart. There is no oxygen charted for one resident requiring continuous oxygen. There is no recorded evidence on one resident’s medication chart of Fentanyl prescription, however the resident was being administered this controlled medicine and this is evidenced in the controlled drug register. The RN contacted the pharmacy and states the wrong page of the second medication chart of the resident receiving Fentanyl was sent to the facility. Correct medication chart was received from the pharmacy on audit day. The GP states the oxygen is charted on past medication charts that was not currently being used.  iv) Five of 12 medication chart do not evidence GP sign off. | Provide evidence medication system complied with legislation, protocols and guidelines. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | There is no recorded evidence of competencies for insulin administration for care staff. | Provide evidence of currency of competencies for all staff who administer insulin. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There are two residents who self- administer medicines. One of two residents has current competency assessment for self -administering medicines, located on file. The RN states this resident has commenced self -administering medicines (inhalers) on day of audit. The RN also states the second resident was attending the GP practice on audit day and competency assessment was to have been completed on audit day, not sighted. This resident has been self -administering medicines for some time. There is no recorded evidence of the residents’ administering sheets for self -administering medicines. Both residents were away from the facility on audit day and could not be interviewed. | Provide evidence of a system to monitor resident’s self -administration of medicines and current competency assessment for residents who self-administer medicines. | 90 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.2 | Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | There are nine residents’ dietary profiles located in the kitchen file. Of the nine dietary profiles, four were last reviewed in 2012, and four in 2013. The 2013 dietary profile reviews occurred in March, April, June and September. The dietary profiles were not sighted in five of five resident files reviewed. | Provide evidence dietary profiles are recorded, reviewed regularly and communicated to kitchen staff. | 90 |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Two freezers located in store room are not checked for temperatures. | Provide evidence of monitoring of freezer temperatures. | 180 |
| 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 | i) Hot water temperatures are not delivered in line with the recommended temperature range.  ii) Electrical equipment does not have current electrical checks. iii) The medical equipment has not been calibrated. | Provide evidence hot water temperatures are within the required temperature range, electrical checks are conducted and medical equipment is calibrated. | 180 |
| HDS(IPC)S.2008 | Standard 3.1: Infection control management | 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. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 3.1.3 | The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | a) Annual review of the 2013 infection control programme has not been conducted; b) bars of soap in communal shower room and c) paper towels not available in all resident rooms. | a) Conduct annual reviews of the infection control programme; b) ensure best practice infection prevention practices are maintained to minimise risk to staff and residents. | 60 |
| HDS(IPC)S.2008 | Standard 3.4: Education | The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 3.4.1 | Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. | PA Low | The nurse manager (infection control nurse) has not attended or completed infection control education in the past two years. | Ensure the infection control nurse maintains their knowledge of current best practice in relation to infection prevention and control. | 90 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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:** |
| Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (two caregivers, one registered nurse, and one nurse manager) confirm their familiarity with the Code. Interviews with six residents and two relatives confirm the services being provided are in line with the Code of rights.  Code of rights/advocacy/complaints training is provided as a regular in-service education and training topic (last provided in June 2012). |

##### 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:** |
| The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with six residents and two relatives identify they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints. On interview, the owner/nurse manager and registered nurse are familiar with the Code and their responsibilities in ensuring that the Code is implemented. Resident/relative meetings are held providing the opportunity to raise concerns in a group setting (last held February 2014). The most recent satisfaction survey (February 2013) includes the question relating to respecting of rights with 100% of the respondents replying they are either satisfied or very satisfied. Advocacy pamphlets, which include contact details, are included in the information pack and are available. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, advocacy and Health and Disability Commissioner information. |

##### 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:** |
| Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.  Discussions with six residents and two relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.  The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.  There are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All six residents and two relatives confirm the service is respectful. A resident and relative satisfaction survey is conducted two yearly. Surveys were completed in February 2013 to gain feedback. Survey questions relating to privacy and respect reflect residents are 100% satisfied or very satisfied. Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family. The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with six residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Five care plans reviewed identify specific individual likes and dislikes. The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect has not been provided in the past two years (link #1.2.7.5).  Discussions with the owner/nurse manager and registered nurse report there have been no identified incidents of abuse or neglect. |

##### 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:** |
| There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.  There are no Maori residents living at the facility at the time of the audit. There is information and websites provided within the facility Maori health plan to provide quick reference and links with local Maori healthcare providers should this be required.  The service utilises a local Maori consultant on an as-needed basis for consultation, this is identified in policy. Interviews with two caregivers and one registered nurse confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural safety and awareness training last provided in September 2012. There is a Maori health plan that includes a description of how they will achieve the requirements set out in the ARC contract. |

##### 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:** |
| Care planning includes consideration of spiritual, psychological and social needs. Six residents indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Two relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the nurse manager and registered nurse. Five of five care plans reviewed include the residents’ social, spiritual, cultural and recreational needs. |

##### 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:** |
| The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the nurse manager. Interviews with two caregivers, one registered nurse and one nurse manager acknowledge their understanding of professional boundaries. |

##### 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:** |
| The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction survey (February 2013) reflect the level of satisfaction with the services that are received. The nurse manager is in charge of the internal audit and in-service education programmes. There is access to computer and internet resources. There are monthly staff meetings and three monthly resident meetings.  Six residents and two relatives interviewed spoke very positively about the care and support provided. Two caregivers, one registered nurse have a sound understanding of principles of aged care and state that they feel supported by the nurse manager. Services are provided at Rata Park that adheres to the Heath & Disability Services Standards (2008). The quality improvement programme includes performance monitoring with areas of improvement required (link #1.2.3.8). There are implemented competencies for caregivers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Policies are in place relating to open disclosure. Six residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.  A sample of incident reports reviewed, and associated resident files, evidenced that family notification is recorded. Two relatives interviewed confirm they are notified of any changes in their family member’s health status. The nurse manager and registered nurse can identify the processes that are in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. The information pack is available in large print and is read to sight-impaired residents. Admission agreements have been recently reviewed and updated to reflect contractual requirements; however, in four of five resident files reviewed, admission agreements were not completed. Improvements are required in this area. Previous error of management charging residents for items, which should have been covered by subsidies, has now been identified and rectified. Advised by management that refunds for previous charged items will be provided to residents. Items included pharmacy charges, doctors’ visits and continence products. |

##### 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:** PA Low |
| **Evidence:** |
| Policies are in place relating to open disclosure. Six residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.  A sample of incident reports reviewed, and associated resident files, evidenced that family notification is recorded. Two relatives interviewed confirm they are notified of any changes in their family member’s health status. The nurse manager and registered nurse can identify the processes that are in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Families are encouraged to visit. The information pack is available in large print and is read to sight-impaired residents. Admission agreements have recently been reviewed and reflect current contractual requirements as evidenced in one of five files reviewed. Four of five files did not evidence a signed admission agreement – improvements are required in this area. |
| **Finding:** |
| Admission agreement for Rata Park has been recently reviewed and updated to reflect contractual requirements; however, in four of five resident files reviewed, admission agreements were not evident. |
| **Corrective Action:** |
| Ensure all residents have a signed admission agreement in place. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five residents’ files (one hospital and four rest home) were reviewed for records pertaining to informed consent processes. All five residents' files record documented informed consent and advance directives and not for resuscitation orders. One of five admission agreements sampled are signed by resident or their legal representative and facility representative (refer to criterion 1.1.9.1). Discussions with residents identifies that the service actively involves them in decisions that affect their lives. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. The residents’ files include information on residents’ family/whanau and chosen social networks. Residents are provided with a copy of the code and nationwide health and disability advocacy services pamphlets on entry. Discussions with two relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. Staff receive education and training around advocacy service during new staff in-service and at least two yearly (last conducted in June 2012). |

##### 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:** |
| The resident information pack informs visiting can occur at any reasonable time. Interviews with six residents and two relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans.  Discussions with six residents and two relatives verify that they are supported and encouraged to remain involved in the community. Rata Park support on-going access to community services (e.g. church, general practitioner visits, family functions). Entertainers are invited to perform at the facility.  Discussions with relatives verify that they are encouraged to be involved with the service and care. |

##### 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:** PA Low |
| **Evidence:** |
| A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service.  Interviews with six residents and two relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.  The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved; however, the register has not been maintained. Improvement is required in this area. There were four resident related complaints lodged in 2013 with only one recorded on the register. One complaint related to a lack of information provided with a resident transferring to another facility. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at the monthly staff meetings. The complaints procedure is provided to residents within the information pack at entry. |

##### 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:** PA Low |
| **Evidence:** |
| The complaints log/register template includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved; however, the register has not been maintained. There were four resident related complaints lodged in 2013 with only one recorded on the register. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. |
| **Finding:** |
| Complaints register has not been maintained. Three of four complaints received in 2013 were not recorded on the register. |
| **Corrective Action:** |
| Maintain an up to date complaints register to record progress and resolution of each complaint. |
| **Timeframe (days):** 90 *(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:** |
| Rata Park provides rest home level care for up to 20 residents with 12 residents accommodated on the day of audit. The current residents include three under 65 year’s old residents. There are currently no respite residents. The service has a strategic business plan in place for organisational governance and direction and a quality plan for 2013/2014. Risk management plans are recorded. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plans. The mission statement of the organisation is included in the admission documentation and states: “To provide a quality, homely environment in which our residents may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race, or creed”. The home is managed by an owner/nurse manager with support from another owner (also registered nurse) and one new graduate registered nurse. Informal management meetings are held between the three management staff to discuss issues relating to occupancy, residents, care issues, and staffing. The nurse manager has attended education in the past 12 months in excess of eight hours relating management of a rest home and includes attendance at a team building exercise, clinical in-service sessions and external clinical education. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the nurse manager, the other owner is in charge. The nurse manager and one registered nurse are responsible for the day-to-day clinical care of residents. The nurse manager is responsible for implementation of the quality and risk management programme. A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality. |

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

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

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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:** PA Low |
| **Evidence:** |
| The nurse manager is responsible for the quality assurance programme at Rata Park. Staff interviewed were conversant with the quality programme.  A set of policies and procedures are in place, which have been reviewed at varying stages over the past two years. An external consultant provides the policies and procedures with regular updates provided. The nurse manager signs off on all new policies. They are available for staff to read and to sign after reading. Policies and procedures are stored in hard copy files at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently.  Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan and a quality plan for 2013/2014. The business plan includes objectives around financial, quality, staff recruitment and retention, professional relationships, internal management, and risk management. The internal audit programme involves monitoring areas of quality and risk including event reporting, complaints management, infection prevention and control, health and safety, and restraint minimisation. A process to measure achievement against the quality and risk management plan is in place. The nurse manager is responsible for ensuring all internal audits are completed and tasks are delegated to the registered nurse and to staff where appropriate. Audits completed for 2013 and 2014 up to date include (but not limited to) laundry, resident files, care plan, food service, recreation, medication, cleaning, infection control, privacy of information, code of rights and restraint. A resident/relative survey was conducted in February 2013 with overall positive feedback.  Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are developed following audits, surveys, and feedback from staff, residents and family, however, there is little evidence to confirm that corrective actions are implemented and signed off when completed. Improvements are required in this area. Results of the internal audits completed are discussed in the monthly staff meetings (minutes reviewed for February 2014). Staff interviewed (two caregivers, one registered nurse) advised that quality information is reported to them via meetings and that they read and sign the communication book. The staff meeting incorporates quality, health and safety, and infection control. Meeting agenda items include discussion on complaints and concerns, health and safety issues, residents rights, food service, training, new staff, housekeeping, incidents and accidents, restraint and hazards. Risks are identified in the risk management plan and hazard register. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme and general staff meeting.  Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear, medication review, clinical assessment, and nutritional support. |

##### 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:** PA Low |
| **Evidence:** |
| Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are developed following audits, surveys, and feedback from staff, residents and family, however, there is little evidence to confirm that corrective actions are implemented and signed off when completed. Improvements are required in this area. Results of the internal audits completed are discussed in the monthly staff meetings (minutes reviewed for February 2014). Staff interviewed (two caregivers, one registered nurse) advised that quality information is reported to them via meetings and that they read and sign the communication book. |
| **Finding:** |
| Corrective actions are not evidenced as implemented or signed off following quality activities |
| **Corrective Action:** |
| Ensure that all corrective actions developed are implemented and signed off when completed. |
| **Timeframe (days):** 90 *(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:** PA Low |
| **Evidence:** |
| Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by either the registered nurse or the nurse manager. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted). There is an accidents and incidents policy, preventing and management of falls policy and monthly incident and accident analysis.  Incident forms sampled for January and February 2014 (16) related to three residents and included one resident with falls, one with behaviours and falls, and one with falls and a skin tear sustained because of a fall. Family interviewed advised that they are informed of any adverse event relating to their relative and this is evident on files and progress notes reviewed. Immediate follow up is conducted by the registered nurse, and GP is notified if required. Caregivers provide first aid and assistance to the resident and can call the nurse manager for assistance if required (who lives on site). Advised that the nurse manager investigates the event and records further follow up and recommendations if required. It is noted that follow up relating to falls assessment, wound assessment chart and care planning related to incidents reviewed has not been conducted for all three residents (link # 1.3.3.3). Nine of 16 forms reviewed were incomplete with further investigations and sign off not recorded. Improvements are required in this area. Monthly incident/accident analysis is conducted and results discussed at staff meetings.  Statutory and regulatory obligations are understood by the owner/nurse manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by either the registered nurse or the nurse manager. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted). There is an accidents and incidents policy, preventing and management of falls policy and monthly incident and accident analysis.  Incident forms sampled for January and February 2014 (16) related to three residents and included one resident with falls, one with behaviours and falls, and one with falls and a skin tear sustained as a result of a fall. Family interviewed advised that they are informed of any adverse event relating to their relative and this is evident on files and progress notes reviewed. Immediate follow up is conducted by the registered nurse, and GP is notified if required. Caregivers provide first aid and assistance to the resident and can call the nurse manager for assistance if required (who lives on site). Advised that the nurse manager investigates the event and records further follow up and recommendations if required. It is noted that follow up relating to falls assessment, wound assessment chart and care planning related to incidents reviewed has not been conducted for all three residents (link # 1.3.3.3). Nine of 16 forms reviewed were incomplete with further investigations and sign off not recorded. Improvements are required in this area. Monthly incident/accident analysis is conducted and results discussed at staff meetings.  Statutory and regulatory obligations are understood by the owner/nurse manager, however, a resident living at Rata Park has been reassessed as hospital level care with no evidence of notification to HealthCERT or the DHB (link 1.3.3). Improvements are required in this area. The owner/nurse manager was able to give examples of instances of notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner. There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing |
| **Finding:** |
| A resident who has been assessed as requiring hospital level care has remained at Rata Park since March 2012. No evidence of notification to relevant authorities has been provided. Advised by a DHB manager, that they were not aware that a resident was living at Rata Park who required hospital level care |
| **Corrective Action:** |
| Ensure HealthCert and DHB have given approval for the hospital level resident to remain in rest home level care |
| **Timeframe (days):** 30 *(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:** PA Low |
| **Evidence:** |
| Incident forms sampled for January and February 2014 (16) related to three residents and included one resident with falls, one with behaviours and falls, and one with falls and a skin tear sustained as a result of a fall. Family interviewed advised that they are informed of any adverse event relating to their relative and this is evident on files and progress notes reviewed. Immediate follow up is conducted by the registered nurse, and GP is notified if required. Caregivers provide first aid and assistance to the resident and can call the nurse manager for assistance if required (who lives on site). Advised that the nurse manager investigates the event and records further follow up and recommendations if required. It is noted that follow up relating to falls assessment, wound assessment chart and care planning related to incidents reviewed has not been conducted for all three residents (link # 1.3.3.3). Nine of 16 forms reviewed were incomplete with further investigations and sign off not recorded. |
| **Finding:** |
| A sample of incident reports reviewed for January and February 2014 evidence that nine of 16 forms are incomplete with investigations, prevention measures and sign off not recorded. |
| **Corrective Action:** |
| Ensure all incident report forms record investigations conducted, opportunities for improvement in service delivery identified and forms signed off when completed. |
| **Timeframe (days):** 60 *(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:** PA Low |
| **Evidence:** |
| There are 16 full time, part time and casual staff employed at Rata Park, which includes an owner/nurse manager, one registered nurse, caregivers, kitchen staff, maintenance, gardening and activities staff. Annual practising certificates, including scope of practice, are validated with copies of certificates held on file. Current practising certificates were sighted for registered nurse, general practitioners and pharmacist. The registered nurse commenced employment in August 2013 and is a new graduate.  Four staff files were randomly selected for review (one registered nurse, two caregivers and one cook). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, and evidence of a completed orientation programme. Competencies are held on file and include medication, food safety, hand washing, fire safety and first aid for appropriate personnel. The registered nurse has completed medication competency and insulin and warfarin administration competency. The care staff files reviewed have completed medication competency but not insulin competency (link #1.3.12.3). Staff sign that they have read and understand their contract and position description. Annual performance appraisals have been conducted for one of the four staff files reviewed. Improvement is required in this area.  Rata Park has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently. Interviews with two caregivers confirm their orientation to the service was thorough. All four staff files reviewed reflected evidence of an orientation programme that had been completed.  A system is in place to identify, plan, facilitate and record on-going education for staff. Education conducted in 2012 and 2013 included wound care, managing difficult behaviours, documentation, medication, safe food handling, safe chemical handling, transferring and lifting, restraint and de-escalation, cultural safety, spirituality, code of consumer rights, advocacy, and informed consent. Training not provided in the past two years includes elder abuse and neglect, sexuality and intimacy, infection control and continence. Improvements are required in this area. The one registered nurse is currently attending a wound care course. Education is provided either as face-to-face sessions, self-directed reading and learning or attendance at off-site sessions. Attendance rates are recorded in individual staff records. Caregivers are encouraged to participate and complete the ACE training programme. One caregiver interviewed has completed the course and one caregiver interviewed has commenced but not completed the course. |

##### 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:** PA Low |
| **Evidence:** |
| Four staff files were randomly selected for review (one registered nurse, two caregivers and one cook). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, and evidence of a completed orientation programme. Competencies are held on file and include medication, food safety, hand washing, fire safety and first aid for appropriate personnel. The registered nurse has completed medication competency and insulin and warfarin administration competency. The care staff files reviewed have completed medication competency but not insulin competency (link #1.3.12.3). Staff sign that they have read and understand their contract and position description. Annual performance appraisals have been conducted for one of the four staff files reviewed.  A system is in place to identify, plan, facilitate and record on-going education for staff. Education conducted in 2012 and 2013 included wound care, managing difficult behaviours, documentation, medication, safe food handling, safe chemical handling, transferring and lifting, restraint and de-escalation, cultural safety, spirituality, code of consumer rights, advocacy, and informed consent. Training not provided in the past two years includes elder abuse and neglect, sexuality and intimacy, infection control and continence. Improvements are required in this area. The one registered nurse is currently attending a wound care course. Education is provided either as face-to-face sessions, self-directed reading and learning or attendance at off-site sessions. Attendance rates are recorded in individual staff records. Caregivers are encouraged to participate and complete the ACE training programme. One caregiver interviewed has completed the course and one caregiver interviewed has commenced but not completed the course. |
| **Finding:** |
| a) Annual staff appraisals not conducted for three of four staff files reviewed; b) training not provided in the past two years includes elder abuse and neglect, sexuality and intimacy, infection control and continence. |
| **Corrective Action:** |
| a) Ensure that annual performance appraisals are conducted for all employees; b) provide evidence that all training requirements have been provided for staff. |
| **Timeframe (days):** 90 *(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:** |
| A good employer policy is in place that includes a documented rationale for staffing. Staffing rosters were sighted and are currently adjusted according to resident numbers and acuity. The owner/nurse manager works full time, lives on site in adjoining quarters, and provides first on call to the facility. The registered nurse works 40 hours per week. Care staff interviewed advised that they are well supported by the registered nurse and owner/nurse manager. Roster includes two caregivers on the morning shift, one on in the afternoon and one overnight. Kitchen staff include a cook. Activities are provided by either an activities coordinator, the nurse manager or care staff. The owner provides maintenance to the facility and care staff attend to cleaning and laundry. Staff turnover is reported by the owner and nurse manager as low.  One general practitioner interviewed confirm that staffing is appropriate to meet the needs of residents. Six residents and two relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents entering the service have all relevant initial information recorded into the resident’s individual files. Residents’ files are protected from unauthorised access by being locked away in the nurses’ station. Residents’ files are integrated and include admission information, assessments, care plans, progress notes, medical notes, and activities plans. Completed incident reports are filed in residents notes. Medication charts are maintained in separate folders. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.  Improvement Note; On review of five files it is noted in progress notes entries that care staff are not recording the time of entry – only the shift. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy for entry criteria is in place. The service’s philosophy is recorded and communicated to residents, family, relevant agencies and staff. This facility operates 24/7.  Five of five residents' files (one hospital and four rest home) were sampled. Four of five residents' files (four rest home) do not evidence admission agreements (refer to criterion 1.1.9.1). There is a facility information pack available for resident and their family. Resident information pack was sighted and contains all relevant information.  Five residents' files ( one hospital and four rest home) sampled demonstrate needs assessments are completed for all four rest home residents at rest home level and one hospital resident at hospital level (refer to criterion 1.3.6.1). Interview with six of six residents (six rest home) and two of two family members (one rest home and one hospital) confirm the admission process was conducted by staff in timely manner. |

##### 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:** |
| System to decline resident entry to the service is documented. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility nurse manager/co-owner. |

##### 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:** PA Moderate |
| **Evidence:** |
| In the resident files sampled (one hospital and four rest home), there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input and the service is coordinated to promote continuity of service delivery.  Four of four clinical staff (one registered nurse (RN), two health care assistants and one facility manager/co-owner (RN)) interviews confirm residents and/or family members are involved in all stages of service provision.  Six of six resident interviews (six rest home) confirm their input into assessment, service delivery planning and care plan evaluations. Five of five residents' files sampled demonstrate the care plans are developed by the RN and there is recorded evidence of the resident and/or family member input.  GP interview was conducted and confirms GP satisfaction with services provided at the facility. GP states they are informed of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.  Facility manager states there is one resident at the facility requiring wound care for chronic wounds. This resident’s wound care was provided by the facility, however this has been taken over by the district nursing services. There are no current wound assessment records or wound treatment plans in the resident’s file. There are areas requiring improvement around service delivery timeframes.   Tracer Methodology Rest Home.  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology Hospital. 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:** PA Moderate |
| **Evidence:** |
| Five resident files were sampled (one hospital and four rest home). The resident files evidence assessments and care planning is conducted by RN. There is resident or family participation in assessment, care planning and care evaluation. GP interview confirms medical issues and concerns are communicated to the GP in timely manner. There are areas requiring improvement around service delivery timeframes in respect of initial assessments and care plans; GP exemptions, GP initial assessments and GP three monthly clinical reviews; monthly weight monitoring and six monthly care plan reviews. |
| **Finding:** |
| i) Initial assessments are not completed on admission in four of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of initial assessments. ii) Initial care plans are not completed on admission in three of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of initial care plans. iii) There is no recorded evidence of GP exemption forms in five of five files reviewed. iv) Two of five files evidence GP clinical reviews are not conducted three monthly. v) GP initial assessments are not conducted as per required timeframes in two of four files reviewed. One file of a resident who was admitted in 2008 was not reviewed in respect of GP initial assessments. vi) Weight monitoring is not occurring monthly in three of five files reviewed. One hospital resident has not been weight since January 2012 due to the facility not having sit on scales. vii) Two of five long term care plans do not evidence six monthly evaluations are occurring. |
| **Corrective Action:** |
| Provide evidence timeframes are adhered to |
| **Timeframe (days):** 90 *(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:** PA Moderate |
| **Evidence:** |
| The service has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN interview confirms that assessments are conducted in a safe and appropriate setting including visits from the doctor. Six of six residents interviewed confirm their involvement in their assessments; care planning, treatment and evaluations of care.  Resident files evidence risk assessments are not consistently conducted on admission and not consistently reviewed along with the resident long term care plan at six monthly intervals or when resident's condition alters and this requires an improvement. |

##### 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:** PA Moderate |
| **Evidence:** |
| Interview with facility nurse manager (RN) confirms resident information is available from a range of sources prior to admission to the facility. NASC assessments are conducted for residents, sighted in all five of five files reviewed. There is evidence of information from other referral sources in the residents' files sampled. Sighted appropriate resources and equipment for RNs to use in the assessment process. |
| **Finding:** |
| Risk assessments are not consistently conducted or reviewed, as required.  i) Rest home resident admitted in September 2013 has no recorded evidence of risk assessments on file.  ii) Hospital resident’s risk assessments were last reviewed in June 2013 and there is no recorded evidence of a dietary profile on file.  iii) Rest home resident admitted in 2012 had risk assessments last reviewed in March 2013. There is no recorded evidence of a continence assessment or a dietary profile on file. iv) Rest home resident admitted in June 2013, had risk assessments completed on admission; however review has not occurred since then. There is no recorded evidence of a dietary profile on file and the pain risk assessment is not dated. v) Rest home resident admitted in March 2013 has completed risk assessments (excluding dietary profile and behavioural assessment) on admission; however no review has occurred since then. |
| **Corrective Action:** |
| Provide evidence risk assessments are conducted on admission and reviewed regularly. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents' files sampled evidence residents' care plans are individualised, however do not consistently record all areas of service requirements (refer to criteria 1.3.4.2 and 1.3.6.1).The long term care plans are not consistently reviewed at regular intervals, at least 6 monthly or as needs change (refer to criterion 1.3.3.3). Residents have input into their care planning and review, confirmed at all six resident interviews.  Residents' files sampled evidence there is evidence of residents and family members participation in care planning and review. The facility has access to regular GP care, confirmed at GP interview. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.  Residents' files sampled evidence the care plans do not consistently record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents (refer to criteria 1.3.3.3 and 1.3.4.2). GPs documentation and records are current in four of five files reviewed (refer to criterion 1.3.3.3). There are adequate continence and dressing supplies in accordance with requirements of the Service Agreement. Six of six residents (six rest home) and two of two family members (one rest home and one hospital) interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communications is recorded in progress notes, sighted in all residents' files sampled.  Care plan audit was conducted in February 2014 with 100% compliance. There is an area required for improvement around recording of residents’ intervention on the care plans. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Six of six residents (six rest home) and two of two family members (one rest home and one hospital) interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communications is recorded in progress notes, sighted in all residents' files sampled. |
| **Finding:** |
| Interventions are not consistently reflected in long-term care plans.  i) Resident admitted in September 2013 has a history of pain, which is not recorded on the long-term care plan. ii) Resident requiring assessment and treatment at DHB in February 2014 has no recorded evidence of the treatment plan recorded on the long-term care plan. iii) Two residents with challenging behaviours do not have this recorded on their long-term care plans. iv) One hospital level care resident is residing in the facility. The resident was admitted in 2008 for rest home level of care and their condition deteriorated in 2012. NASC reassessment was conducted in March 2012. A letter dated 27/3/12 records the NASC reassessment for hospital level of care and that family requested that the resident remains at the facility as long as possible. Admission agreement was sighted to be signed in 2008. |
| **Corrective Action:** |
| Provide evidence interventions are recorded on care plans and only rest home level of care residents reside at the facility, as the facility is providing rest home category of services only.` |
| **Timeframe (days):** 90 *(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:** |
| Interview with the facility nurse manager was conducted, as the activities co-ordinator (AC) was unavailable on audit day. The facility nurse manager confirms that in December 2013, the past AC resigned and the activities programme was run by the facility nurse manager for December 2013 and January 2014 until a new AC was appointed. The facility nurse manager states there was no planned / recorded activities programme for December 2013 and January 2014. The present AC is employed two days a week and the rest of the programme for the week is managed by the facility nurse manager. The activities weekly programme does not record residents’ outings and the facility nurse manager states the outings are not planned and are weather dependent. The facility has one van that can accommodate three wheelchairs and three residents and a 23 seated bus. Residents’ activities attendance records are maintained and were sighted.  Residents' two monthly meeting were sighted. Residents' files sampled record the activities are part of the long term care plans and demonstrate support is provided within the areas of leisure and recreation, health and well-being.  Activities audit was conducted in January 2014 with corrective actions to be implemented (refer to criterion1.2.3.8).  Six of six residents and two of two family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities. |

##### 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:** |
| Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. Residents' files sampled evidence that evaluations of care plans are not within stated timeframes (refer to criterion 1.3.3.3). Evaluations are conducted by the RN with input from the resident, family, health care assistants and GP.  Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews.  Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.  There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional.  There is an area requiring improvement around the use of short term care plans. |

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Care plan evaluation are conducted by the RN with input from the resident, family, health care assistants and GP, sighted on the care plan reviewed.  Family are notified of any changes in resident's condition and this is recorded on the resident’s progress notes. Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. |
| **Finding:** |
| Short term care plans are not consistently recorded and completed for short term problems. i) A resident sustained a fall outside of facility in January 2014. This event is recorded in resident’s progress notes and on an incident form. The injuries sustained (skin tears) are not recorded on a short term care plan, or entered onto the long term care plan or recorded on a wound assessment and treatment form. ii) There is evidence of a short term care plan (June 2013) for a short term problem for the hospital resident, however this is not signed of as resolved. iii) Resident requiring investigation/preparation at DHB in December 2013 and February 2014 has no recorded evidence of this as a short term problem. |
| **Corrective Action:** |
| Provide evidence of the use and completion of short term care plans. |
| **Timeframe (days):** 90 *(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:** |
| Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.  Residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication is occurring. |

##### 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:** |
| Residents’ files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files. |

##### 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:** |
| There is a secure medicine management system in place and medicines are stored in their original dispensed packs. The medication trolley is located in staff office. The controlled drugs storage in the facility is also located in the office and is secure. The controlled drug register is maintained and evidences six monthly physical stock takes on the register, however weekly checks are not conducted. Fridge temperatures where medicines are stored are conducted and recorded.  Residents' medicine charts do not list all medications a resident is taking. The pharmacy generates a new medication chart each time a new medicine is added or altered by the GP. The GP states the new medication chart loses the PRN medication or any other medication that is not in the blister pack and the new medication chart is generated by the pharmacy and used by the facility prior to GP sign off. Medication round was observed and evidences the RN signs off, as the dose is administered. The staff who administer medicines have current medication competencies, however there are no competencies in insulin administration for care staff. Staff education in medicine management was conducted in April 2013. Twelve medicine charts were sampled and all charts demonstrate residents' photo identification, medicine charts are legible (typed by pharmacy) and discontinued medicines are dated and signed by the GP.  There are two residents at the facility who self-administer medicines.  Medication audit was conducted in December 2013 with corrective action required (refer to criterion 1.2.3.8). There are areas requiring improvement around the medication system to comply with legislation, protocols and guidelines, staff competencies for insulin administration and monitoring resident’s self- administration of medicines and current competency assessment for residents who self-administer medicines. |

##### 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:** |
| There is a secure medicine system in place. Fridge temperatures where medicines are stored are conducted and recorded.  The staff who administer medicines have current medication competencies, except insulin administration. Twelve medicine charts were sampled and all charts demonstrate residents' photo identification, medicine charts are legible (typed by pharmacy) and discontinued medicines are dated and signed by the GPs. |
| **Finding:** |
| i) Controlled drug register does not evidence weekly checks are conducted. ii) Two of 12 medication charts do not evidence three monthly reviews. iii) Residents' medicine charts do not list all medications a resident is taking. The pharmacy generates a new medication chart each time a new medicine is added or altered by the GP. The GP states the new medication chart loses PRN medication or any other non-packaged medication off the medicine chart. There is no oxygen charted for one resident requiring continuous oxygen. There is no recorded evidence on one resident’s medication chart of Fentanyl prescription, however the resident was being administered this controlled medicine and this is evidenced in the controlled drug register. The RN contacted the pharmacy and states the wrong page of the second medication chart of the resident receiving Fentanyl was sent to the facility. Correct medication chart was received from the pharmacy on audit day. The GP states the oxygen is charted on past medication charts that was not currently being used.  iv) Five of 12 medication chart do not evidence GP sign off. |
| **Corrective Action:** |
| Provide evidence medication system complied with legislation, protocols and guidelines. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The staff who administer medicines have current medication competencies, however there are no competencies in insulin administration for care staff. Staff education in medicine management was conducted in April 2013. The RN holds current competency in insulin administration. |
| **Finding:** |
| There is no recorded evidence of competencies for insulin administration for care staff. |
| **Corrective Action:** |
| Provide evidence of currency of competencies for all staff who administer insulin. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.5 (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:** PA Moderate |
| **Evidence:** |
| There is a policy on self -administration of medication. |
| **Finding:** |
| There are two residents who self- administer medicines. One of two residents has current competency assessment for self -administering medicines, located on file. The RN states this resident has commenced self -administering medicines (inhalers) on day of audit. The RN also states the second resident was attending the GP practice on audit day and competency assessment was to have been completed on audit day, not sighted. This resident has been self -administering medicines for some time. There is no recorded evidence of the residents’ administering sheets for self -administering medicines. Both residents were away from the facility on audit day and could not be interviewed. |
| **Corrective Action:** |
| Provide evidence of a system to monitor resident’s self -administration of medicines and current competency assessment for residents who self-administer medicines. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.3.12.6 (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:** PA Low |
| **Evidence:** |
| Food service policies and procedures are appropriate to the service setting with a new seasonal three weekly menu being introduced six monthly.  The menu is being reviewed by a dietitian presently, correspondence sighted to be dated March 2014. Last menu review was conducted June 2012. There are documented protocols for management of residents with unexplained weight loss or gain.  Residents' dietary requirements are not always identified, documented and reviewed on a regular basis, as part of the care plan review. Food safety training for kitchen staff have been conducted, confirmed at interview with the cook.  Residents' files sampled demonstrate monthly monitoring of individual resident's weight is not always occurring (refer to criterion 1.3.3.3).  Food temperatures are recorded, sighted. Fridge and freezer temperatures are recorded, sighted. Two additional freezers are not being monitored for temperatures.  Kitchen services audit was conducted in January 2014 and corrective actions required (refer to criterion 1.2.3.8).  Food safety education for staff was last conducted in March 2013. There are areas required for improvement around residents’ dietary profiles and monitoring of freezer temperatures. |

##### 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:** PA Low |
| **Evidence:** |
| Residents interviewed were satisfied with the food service provided, report their individual preferences are catered and adequate food and fluids are provided. |
| **Finding:** |
| There are nine residents’ dietary profiles located in the kitchen file. Of the nine dietary profiles, four were last reviewed in 2012, and four in 2013. The 2013 dietary profile reviews occurred in March, April, June and September. The dietary profiles were not sighted in five of five resident files reviewed. |
| **Corrective Action:** |
| Provide evidence dietary profiles are recorded, reviewed regularly and communicated to kitchen staff. |
| **Timeframe (days):** 90 *(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:** PA Low |
| **Evidence:** |
| The fridge and freezer located in the kitchen is monitored for temperatures. Sighted records of temperature monitoring. |
| **Finding:** |
| Two freezers located in store room are not checked for temperatures. |
| **Corrective Action:** |
| Provide evidence of monitoring of freezer temperatures. |
| **Timeframe (days):** 180 *(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:** |
| There are policies for the management of waste and hazardous substances. Hazardous substances are correctly labelled. Sluice room is available for the disposal of waste and hazardous substances. Material safety data sheets are available for staff. Staff receive training and education in chemical safety, last provided in February 2013. Protective clothing and equipment is appropriate to the risks associated with waste or hazardous substance being handled, are provided and used by staff, confirmed at staff interview. |

##### 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:** |
| There is a current Building Warrant of Fitness that expires 27 June 2014. Facility nurse manager/co-owner was interviewed and confirms there is a preventative and reactive maintenance programme in place, sighted. There is safe storage of medical equipment. There are appropriately located and secure safety rails, equipment does not clutter passageways and floor surfaces/coverings are appropriate to the resident group and setting. The external areas include a veranda and a garden setting with seating, appropriate to the resident group and setting.  Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.  There are areas required for improvement around hot water temperatures, electrical checks and calibration of medical equipment. |

##### 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 reactive and preventative maintenance programmes are in place. The facility nurse manager/ co-owner is responsible for the maintenance programme. There is a grounds man employed to maintain the external areas. Current building warrant of fitness is displayed. Hot water temperatures are monitored, however they are not delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies, as determined by the Building Regulations 1992 (Acceptable Solutions). Sighted hot water temperatures for  February and March 2014. Hot water temperature records for February 2014 record a plumber was contacted in respect of the higher water temperature readings. There is no recorded data of the hot water temperature readings post plumber alterations to regulate the water temperatures (refer to criterion 1.2.3.8.). There were no hot water temperature readings for 2013 available on audit day. Some electrical equipment has current electrical check, however majority of the electrical equipment was due for electrical checks in May 2013. Interview with the facility nurse manager / co –owner confirms the medical equipment calibrations have not been conducted. |
| **Finding:** |
| i) Hot water temperatures are not delivered in line with the recommended temperature range.  ii) Electrical equipment does not have current electrical checks. iii) The medical equipment has not been calibrated. |
| **Corrective Action:** |
| Provide evidence hot water temperatures are within the required temperature range, electrical checks are conducted and medical equipment is calibrated. |
| **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:** |
| There is an adequate number of communal toilet and shower facilities.  Toilet and shower facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All toilets and shower facilities have appropriate access for residents and have a system that indicates if it is engaged or vacant. Appropriately, secure and approved handrails are provided and other equipment/accessories are made available to promote resident independence. There is a separate staff/ visitor toilet. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are 15 single occupancy rooms and five double rooms, of which two are being shared by residents, on audit day. The double rooms have privacy curtains. All residents’ rooms have hand basins (refer to criterion 3.1.1)  There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. |

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

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

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

ARC E3.4b ARHSS D15.3d

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate access provided to the lounge and dining room at the facility. Residents were observed to be moving freely within these areas. Residents were observed to be using the covered veranda and external areas. |

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

#### Standard 1.4.6: 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:** |
| Cleaning and laundry policy and procedures are available and include safe storage and use of chemicals. All linen is washed on site and there is adequate dirty / clean flow. Laundry / cleaning staff member was interviewed and describes management of laundry including transportation, sorting, storage, laundering, and return to residents. The staff member responsible for laundry and cleaning at the facility is employed for four days a week (Tuesday to Friday) and states on the days when they are not at the facility, the care staff do the laundry and cleaning duties. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. Cleaning audit was conducted in December 2013 and required corrective action, and this was re-audited in January 2014. Laundry audit was last conducted in May 2013. There is safe and secure chemical storage areas, chemicals are appropriately labelled and stored safely within these areas. Chemical safety data sheets are available. Appropriate facilities exist for the disposal of soiled water/waste. Hand washing facilities are available. Residents and family interviewed state they are satisfied with the cleaning and laundry services. |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures and training for civil defence, other emergencies and security. Emergency management training occurs as part of orientation for new staff. All staff have a current first aid certificate. The New Zealand Fire Service approved the fire evacuation scheme on the 22 February 2002. Advised that fire evacuation drills occur six monthly – last conducted 6 March 2014. Battery operated emergency lighting, extra torches and gas cooking is in use/available. The service has the use of a generator if required in an emergency. Call bells are evident in resident’s rooms and toilets/bathrooms. Security policies and procedures are in place. There is a civil defence kit available and first aid supplies. The service has extra food and water available, should the need arise, enough for at least three days. Staff conduct security checks in the evenings to ensure the facility is secure. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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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:** |
| The residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area on the veranda. Facility nurse manager interview confirms there is an alternative smoking area for residents, if this is required and requested by residents’ who do not smoke and may be affected by smoke. Residents interviewed confirm the facilities are maintained at an appropriate temperature. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **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:** |
| Rata Park has comprehensive policies and procedures on restraint minimisation and safe practice. One registered nurse is the restraint coordinator. Policy states that enablers are voluntary. There are currently no residents assessed as requiring restraint or enablers. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers. The service has a restraint/enabler register for use if required. Restraint and de-escalation techniques education was last provided in October 2012. Managing difficult behaviours training was provided in May 2013. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Rata Park has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by the external policy provider. The facility nurse manager is the infection control nurse. Discussion and reporting of infection control matters is conducted at the general staff meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Education is has not been provided for staff in the past two years (link #1.2.7.5). The annual review of the 2013 programme has not been conducted. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors, however, during a tour of the facility is was noted that bars of soap are in use in one communal shower room and paper hand towels are not available in all resident rooms. Improvements are required in these areas. Alcohol hand gel is available and utilised. |

##### 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:** PA Low |
| **Evidence:** |
| Infection control is a standing agenda item are staff meetings. Discussion is held in regards to infection rates and issues. The annual review of the 2013 programme has not been conducted. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors, however, during a tour of the facility is was noted that bars of soap are in use in one communal shower room and paper hand towels are not available in all resident rooms. Alcohol hand gel is available and utilised. |
| **Finding:** |
| a) Annual review of the 2013 infection control programme has not been conducted; b) bars of soap in communal shower room and c) paper towels not available in all resident rooms. |
| **Corrective Action:** |
| a) Conduct annual reviews of the infection control programme; b) ensure best practice infection prevention practices are maintained to minimise risk to staff and residents. |
| **Timeframe (days):** 60 *(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 facility nurse manager is the infection control (IC) nurse. He is supported by one other owner/RN, one other registered nurse and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and staff have good external support from the local laboratory infection control team and IC nurse at the Southern district health board. The infection control team is representative of the facility. |

##### 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 are infection control policy and procedures appropriate to for the size and complexity of the service. The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are reviewed and updated by the clinical nurse manager to ensure best practice information is included. The policies and procedures were last updated and reviewed in May 2013. Rata Park infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; personal protective equipment, medical waste and sharps and spills management. |

##### 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:** PA Low |
| **Evidence:** |
| The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse. Infection control education has not been provided in 2013 (link #1.2.7.5). Infection control education is provided at orientation for new staff and includes hand hygiene. Staff complete an infection control hand washing audit – conducted in May 2013. It is noted that the infection control nurse has not attended or completed infection control education in the past two years. Improvements are required in this area. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been reported in the past two years. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse. Infection control education is provided at orientation for new staff and includes hand hygiene. Staff complete a hand washing audit – last conducted May 2013. |
| **Finding:** |
| The nurse manager (infection control nurse) has not attended or completed infection control education in the past two years. |
| **Corrective Action:** |
| Ensure the infection control nurse maintains their knowledge of current best practice in relation to infection prevention and control. |
| **Timeframe (days):** 90 *(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:** |
| Infection surveillance is an integral part of the infection control programme and is described in Rata Park infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the general staff meetings. If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past two years. |

##### 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:** |
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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.)* |