# The Ultimate Care Group Limited - Allen Bryant Lifecare

## Current Status: 27 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

Allen Bryant Lifecare in Hokitika on the west coast provides rest home and hospital level care for up to 46 residents. On the day of the audit the facility is at full capacity of 29 hospital and 17 rest home residents. The service is managed by an experienced team of a manager and clinical nurse manager (CNM). There is evidence of reporting by management to the governing body, the Ultimate Care Group Limited. There is a well-established and implemented quality and risk programme to ensure service needs are met and monitored. Staff, residents and family members report being happy with and are very complimentary of the facility.

Two areas requiring improvement, both low risk, have been identified during this certification audit. These relate to activity plans and formalising the food waste disposal process.

## Audit Summary as at 27 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 27 March 2014

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

### Organisational Management as at 27 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 27 March 2014

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

### Safe and Appropriate Environment as at 27 March 2014

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

### Restraint Minimisation and Safe Practice as at 27 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 27 March 2014

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

## Audit Results as at 27 March 2014

### Consumer Rights

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) including the facility's complaints process and the Nationwide Health and Disability Advocacy Service is on display in the communal lounge, is available on admission in the admission package, and on request as required.

There is evidence of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence. Residents and family members interviewed state that all staff are respectful of their needs, that communication is appropriate, and they have a clear understanding of their rights and the facility’s processes if these are not being met.

Consent forms are provided prior to admission to ensure residents and family members have time for consultation and are fully informed. Time is provided if discussions and explanation is required.

There is a fully implemented complaints management system which includes open disclosure of any situation that occurs.

### Organisational Management

The Ultimate Care Group is a group of aged care facilities throughout New Zealand with a centralised senior management structure, and management teams in the individual facilities. Like most of Ultimate Care Group’s facilities Allen Bryant Lifecare has a management team of a business manager and clinical nurse manager who run the service in partnership. In addition to the clinical nurse manager there is a team of registered nurses, one of whom acts as a senior nurse on duty in the rare absence of both the business manager and clinical nurse manager.

The Ultimate Care Group has a comprehensive quality and risk management system which is well implemented at Allen Bryant Lifecare. All exceptions to expected service delivery are reported and addressed. Collated data is reported through to the regional manager and senior management team, and is analysed on site by the quality group. Corrective action plans are developed in response to events and trends when needed.

There is a documented staffing plan which is used as a basis for rostering a safe number of staff across the facility and all shifts. This includes 24 hour registered nurse cover in the facility (with an additional nurse on call at weekends), trained caregivers, cooks, housekeeping staff, and a maintenance person.

Residents’ individual files are maintained securely when not in use in one of the two nurses stations and records are well maintained and current.

### Continuum of Service Delivery

A detailed admission package provides prospective residents with the process required for admission to Allen Bryant, including the need for all residents to be assessed prior to admission.

The registered nurse (RN) completes the initial nursing assessments from which a comprehensive and detailed lifestyle care plan is developed. Regular reviews occur to ensure assessed needs are documented and service delivery is provided in a timely manner. Care staff are observed providing services in a respectful and dignified manner, which reflects the care plan content. This is supported in resident and family interviews. A general practitioner (GP) is interviewed during the audit and confirms the facility provides services in line with treatment recommendations, that RN assessments are appropriate and that she is notified in a timely manner of any issues that arise.

An activities programme is planned and implemented by the activities person, however it may not always meet the social activity of all the residents, and individual resident’s activity plans are not detailed to reflect the social needs and interests of the residents, and these areas need improvement.

A 'blister pack' medication system is implemented and care staff or RNs, assessed as competent to do so, follow a GP prescription record to administer the medications. This process is observed on the day of the audit. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as any changes to the prescription occur.

A dietary profile is completed for each resident on admission and any special dietary needs are met. Personal likes and dislikes are catered for, and birthdays and special occasions are celebrated. The kitchen service is managed from within the facility by a chef, supported by kitchen staff. A nutritional review of the menu has occurred in the past two years and observation of the meals provided reflects the menu. Appropriate monitoring of food procurement, transportation and storage of food occurs. There is no formal agreement for disposal of food waste, collected daily for pig feed, in keeping with the Ministry of Primary Industries Biosecurity regulations 2005. This is an area for improvement.

### Safe and Appropriate Environment

The environment in the facility is well maintained and in good order. The corridors are wide and spacious throughout the building and have secure handrails at an appropriate height around the whole facility. The floor coverings, curtains and all other furnishings and surfaces are appropriate for the residents and promote safety. The facility is kept clean and tidy at all times and is odour free.

The organisation has systems and documentation to guide staff in maintaining a hygienic environment. Waste and hazardous substances are managed and other cleaning and laundry is effective.

The building has a current warrant of fitness and fire safety systems are in place and functioning. There is appropriate planning for emergencies and the facility is secure.

### Restraint Minimisation and Safe Practice

The Ultimate Care Group has policies and procedures to guide staff in the safe use of restraints when these are determined to be necessary. There is an emphasis on minimisation of restraint use which is evident in staff interviews and records reviewed. Alternatives to the use of any restraints are explored and use is discontinued immediately if it is contra-indicated.

Staff receive annual training in the organisation’s policies and procedures for restraint use. Restraint use is reviewed regularly by the facility’s approval group. This group always includes a family/whanau representative. Restraint use data is incorporated into the quality improvement data. This is shared with all staff at the monthly staff meetings and the quality improvement committee meetings.

### Infection Prevention and Control

There is a documented and implemented infection control (IC) programme which meets the IC Standards. Policies and procedures are in place to guide staff. Records sighted, observation and interviews with staff provides evidence that staff have a clear understanding of what is required for prevention of infections. The clinical nurse manager (CNM) ensures the programme is implemented, collates and analyses IC data, and reports findings to the quality committee.

The CNM gains advice from a variety of external sources. The GP is also consulted regarding individual resident’s infections. Surveillance of infections is occurring.

All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices and when visiting the facility.

# 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:** | The Ultimate Care Group Limited |
| **Certificate name:** | The Ultimate Care Group Limited - Allen Bryant Lifecare |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Allen Bryant Lifecare | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 27 March 2014 | **End date:** | 28 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:** | 46 |

## **Audit Team**

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

## **Sample Totals**

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

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 55 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Thursday, 24 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Allen Bryant Lifecare in Hokitika on the West Coast provides rest home and hospital level care for up to 46 residents. On the day of the audit the facility is at full capacity of 29 hospital and 17 rest home residents. Included in the 29 hospital residents are four residents under the younger person’s with a disability (YPD) contract. The service is managed by an experienced team of a manager and clinical nurse manager (CNM). There is evidence of reporting by management to the governing body, the Ultimate Care Group Limited. There is a well-established and implemented quality and risk programme to ensure service needs are met and monitored. Staff, residents and family members report being happy with and are very complimentary of the facility.  Two areas requiring improvement, both low risk, have been identified during this certification audit. These relate to activity plans and food waste disposal. |

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| **Outcome 1.1: Consumer Rights** |
| Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) including the facility's complaints process and the Nationwide Health and Disability Advocacy Service is on display in the communal lounge, is available on admission in the admission package, and on request as required.  There is evidence of consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence. Residents and family members interviewed state that all staff are respectful of their needs, that communication is appropriate, and they have a clear understanding of their rights and the facility’s processes if these are not being met.   Consent forms are provided prior to admission to ensure residents and family members have time for consultation and are fully informed. Time is provided if discussions and explanation is required.  There is a fully implemented complaints management system which includes open disclosure of any situation that occurs. |

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| **Outcome 1.2: Organisational Management** |
| The Ultimate Care Group is a group of aged care facilities throughout New Zealand with a centralised senior management structure, and management teams in the individual facilities. Like most of Ultimate Care Group’s facilities Allen Bryant Lifecare has a management team of a business manager and clinical nurse manager who run the service in partnership. In addition to the clinical nurse manager there is a team of registered nurses, one of whom acts as a senior nurse on duty in the rare absence of both the business manager and clinical nurse manager.   The Ultimate Care Group has a comprehensive quality and risk management system which is well implemented at Allen Bryant Lifecare. All exceptions to expected service delivery are reported and addressed. Collated data is reported through to the regional manager and senior management team, and is analysed on site by the quality group. Corrective action plans are developed in response to events and trends when needed.   There is a documented staffing plan which is used as a basis for rostering a safe number of staff across the facility and all shifts. This includes 24 hour registered nurse cover in the facility (with an additional nurse on call at weekends), trained caregivers, cooks, housekeeping staff, and a maintenance person.   Residents’ individual files are maintained securely when not in use in one of the two nurses stations and records are well maintained and current. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| A detailed admission package provides prospective residents with the process required for admission to Allen Bryant, including the need for all residents to be assessed prior to admission.  The registered nurse (RN) completes the initial nursing assessments from which a comprehensive and detailed lifestyle care plan is developed. Regular reviews occur to ensure assessed needs are documented and service delivery is provided in a timely manner. Care staff are observed providing services in a respectful and dignified manner, which reflects the care plan content. This is supported in resident and family interviews. A general practitioner (GP) is interviewed during the audit and confirms the facility provides services in line with treatment recommendations, that RN assessments are appropriate and that she is notified in a timely manner of any issues that arise.   An activities programme is planned and implemented by the activities person, however it may not always meet the social activity of all the residents, and individual resident’s activity plans are not detailed to reflect the social needs and interests of the residents, and these areas need improvement.  A 'blister pack' medication system is implemented and care staff or RNs, assessed as competent to do so, follow a GP prescription record to administer the medications. This process is observed on the day of the audit. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as any changes to the prescription occur.  A dietary profile is completed for each resident on admission and any special dietary needs are met. Personal likes and dislikes are catered for, and birthdays and special occasions are celebrated. The kitchen service is managed from within the facility by a chef, supported by kitchen staff. A nutritional review of the menu has occurred in the past two years and observation of the meals provided reflects the menu. Appropriate monitoring of food procurement, transportation and storage of food occurs. Food waste is placed in a bin for pigs and this practice requires improvement. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The environment in the facility is well maintained and in good order. The corridors are wide and spacious throughout the building and have secure handrails at an appropriate height around the whole facility. The floor coverings, curtains and all other furnishings and surfaces are appropriate for the residents and promote safety. The facility is kept clean and tidy at all times and is odour free.   The organisation has systems and documentation to guide staff in maintaining a hygienic environment. Waste and hazardous substances are managed and other cleaning and laundry is effective.   The building has a current warrant of fitness and fire safety systems are in place and functioning. There is appropriate planning for emergencies and the facility is secure. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The Ultimate Care Group has policies and procedures to guide staff in the safe use of restraints when these are determined to be necessary. There is an emphasis on minimisation of restraint use which is evident in staff interviews and records reviewed. Alternatives to the use of any restraints are explored and use is discontinued immediately if it is contra-indicated.   Staff receive annual training in the organisation’s policies and procedures for restraint use. Restraint use is reviewed regularly by the facility’s approval group. This group always includes a family/whanau representative. Restraint use data is incorporated into the quality improvement data. This is shared with all staff at the monthly staff meetings and the quality improvement committee meetings. |

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| **Outcome 3: Infection Prevention and Control** |
| There is a documented and implemented infection control (IC) programme which meets the IC Standards. Policies and procedures are in place to guide staff. Records sighted, observation and interviews with staff provides evidence that staff have a clear understanding of what is required for prevention of infections. The clinical nurse manager (CNM) ensures the programme is implemented, collates and analyses IC data, and reports findings to the quality committee.   The CNM gains advice from a variety of external sources. The GP is also consulted regarding individual resident’s infections. Surveillance of infections is occurring.  All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices and when visiting the facility. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 0 | 0 | 0 |

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

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Seven activity plans are reviewed. Those reviewed do not always have a written activity plan that reflects the desired social activity of the resident, as required in ARRC D16.5ciii. For example one resident who attends the gym, and another resident who goes into town for coffee, do not have these regular outings facilitated by the activities person, included in the resident’s activity plans.  Other plans reviewed have not been evaluated and reviewed each time the care plan is reviewed, as required in ARRC D16C iii.  The activity person is interviewed and prepares the activity programme, which is repetitive, each month, and may not always include enough variety to meet the needs of all residents, although a family member interviewed stated that the activities provided are suitable for her husband.  There are three van trips out each week, and the van can only take six plus one in a wheelchair; however records sighted noted that of those in the van, there are consistently at least the same three residents who go on the outings. The record to identify those who have been asked to go and declined has not been maintained. Three residents interviewed confirmed that the same residents go out each time in the van | Activities are planned and provided to meet the skills, resources and interests of the resident, and are meaningful to the resident and meet the requirements of ARRC D16.5c. | 180 |
| 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 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Food waste is disposed into a bin that is collected daily for pig feed. There is no formal agreement in keeping with the guidelines of the MPI (Ministry of Primary Industries) Biosecurity (Meat and food waste for pigs) regulations 2005. | Formalise the agreement related to the collection of food waste as per the current regulations. | 180 |

## **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:** |
| Training in the Code of Health and Disability Services Consumers’ Rights’ (the Code) occurs at least annually (records sighted). Care staff are observed communicating respectfully and appropriately with residents and allowing residents to make choices (for example, when they wish to get up, clothing choices, and where they wish to have their lunch), demonstrating their knowledge of residents’ rights.  Residents (four of four) and family member (three of three) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld.   The ARRC requirements D1.1c; D3.1 are met. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and family members interviewed, confirm they are provided with information regarding the Code, and the Nationwide Health and Disability Advocacy Service, in the admission package provided by the facility prior to the resident’s admission. Those interviewed verify explanations regarding their rights occur initially and on-going at any time that they may have a query, and they are aware that an advocate may be appointed if needed. One of one resident and family member confirms that they contacted the advocacy service prior to admission to the facility, but have not needed to since their admission to Allen Bryant.  A laminated poster of the Code is visible in the entrance to the lounge area, and brochures of the Code and the advocacy service are available (sighted) at the entrance to the facility, and included in the admission package.  The ARRC requirements D6.1; D6.2; D16.1b.iii are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Guidelines for privacy and dignity describe clear and specific behaviours expected of staff when supporting residents (policy sighted). Observation during the audit confirms residents are encouraged and supported to maintain independence, and are treated with dignity and respect. Doors are closed and curtains are drawn to protect resident’s privacy when service delivery occurs. The facility has installed curtains on either side of the toilet area for added privacy, and these are observed to be used regularly.   Documentation sighted (care plans) includes the cultural, spiritual and ethnic values and beliefs for each resident (seven of seven files reviewed). One of one Maori resident file reviewed includes tribe, iwi, and any visiting kaumatua (sighted).  Policies and procedures include those relating to abuse and neglect prevention are sighted. Staff interviewed (three of three) are able to demonstrate knowledge in what abuse and neglect is, and the reporting processes. Residents and family members interviewed have not been subject to, or witnessed any abuse or neglect, and verify that they observe staff as always respectful to the residents.  The ARRC D3.1b; D3.1d; D3.1f; D3.1i; D4.1a; are met. |

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

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

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

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

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

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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:** |
| The organisation has a Maori Health Plan, a Maori Health Policy, Maori perspective on health, and cultural safety policy. The Maori Health Plan includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. It describes that the holistic view of Maori health is to be incorporated into the delivery of services (whanau, hinangaro, tinana and wairua), which is observed in practice, confirmed by one of one Maori resident, and sighted in the resident’s file reviewed.  The ARRC requirements A3.1; A3.2; D20.1i are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Recognition of Individual Beliefs and Values policy (sighted) describes the process of including each person’s own values and beliefs into their care plan and doing this with family/whanau involved in the process. This process is verified by resident and family members and verified in residents’ files reviewed. Staff receive regular training in supporting residents to achieve their values and beliefs and in assisting them to practice any cultural activities which they choose. For example, one of one resident who chooses to visit a church nearby has this facilitated by the rest home.  The need to access interpreters and the need for sensitivity and respect of cultural differences is included in the policy (sighted) and observed in practice with a resident who has identified a preference to staff of their own culture, and this is supported by the facility.   Residents and family members interviewed verify the facility regularly ensures their individual values and beliefs are met.   The ARRC requirements D3.1g; D4.1c are met. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff induction and orientation programme (sighted) includes expected behaviour in relation to discrimination, coercion, harassment, sexual and financial exploitation. Three of three staff interviewed confirm that they do not accept gifts or any other inducement, and can describe the facility’s policy in relation to discrimination, harassment and other exploitation. |

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

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

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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:** |
| Induction and orientation for staff is aligned to best practice processes. Each staff member has a written scope of practice included in their position description (sighted), including if they have multiple roles (for example the RN is also the infection control co-ordinator).  In-service education and on-going professional development is provided and supported by the organisation (records sighted). Policies and procedures are all current and reflect good practice guidelines.  The facility’s assessments and care plans are comprehensive and detailed and are reviewed every three months or sooner if required. Resident files reviewed include multidisciplinary team (MDT) meetings and family communication forms completed in the timeframes specified. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are guidelines (sighted) for communicating with residents, relatives and visitors which sets out expected behaviours of staff, and observed during the audit to reflect the policy guidelines. For example staff are heard addressing people as Mr or Mrs and their surname unless they have indicated to use a first name. The Language policy (sighted) that directs staff to speak English in front of residents / family / whanau (observed in practice for those staff for which English is a second language).  Communication is observed to be appropriate and residents are given time to answer. Residents and family members interviewed verify that staff ensure that they are understood and communication is respectful.  Open Disclosure occurs according to the facility’s policy (sighted). Indication on two of two incident reports that a family member has been notified, and this is verified in family communication form the discussion that took place (sighted).  The nurse manager (NM) and registered nurse (RN) are interviewed and verify that interpreter services have not been used for any residents in recent months, but are able to confirm how these needs would be met, if required.  The ARRC requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy on Informed Consent is reviewed and includes references to the Code in relation to competence and how to assess whether a resident is deemed medically unable to give informed consent themselves. Seven residents’ files are reviewed and they all include consent for photographs, name on the door and publicly displayed records to be retained, health information and care provision, advance directives, outings and flu vaccinations.  Residents and family members confirm that staff gain consent for day to day activities on a daily basis.  Admission agreements are signed by the resident and/or their family member on admission to the facility, and information included is aligned to the ARRC agreement requirements. This is confirmed in seven of seven residents’ agreements reviewed.  The ARRC requirements D3.1d; D11.3; D12.2 are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** 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:** |
| There are policies and procedures (sighted) that include the right of residents to have an advocate or support person of their choice. The contact details for advocacy services and the Health and Disability Commissioner are included in the policy document. Residents (four of four) and family (three of three) interviewed, confirm that family and support persons are included in discussions relating to care provision. This is confirmed in the multidisciplinary team (MDT) meeting records (sighted) that includes input from the resident’s family member.  Care staff (interviewed) are aware of the residents’ rights to have a support person of their choice at any time, and this has been facilitated in a recent meeting with one resident (records sighted).  The ARRC requirements D4.1d; D4.1e are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and family members interviewed verify that family and visitors of their choice are able to visit residents at any time. External community links are encouraged and enable to continue. One resident interviewed visits the gym three times a week with a family member, while another interviewed goes into town three times a week ‘for a cuppa’. Progress notes and care plan content includes regular outings and appointments (records sighted).  The ARRC requirements D3.1h; D3.1e are met. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| UCG has an appropriate complaint management policy and procedure which meets the requirements of the standards. There is an electronic register which is maintained at the facility and is current. This includes the type of complaint, the actions taken in response to the complaint and the status of the complaint.   Resident and family/whanau satisfaction survey results for 2013 demonstrate there is satisfaction with the way in which complaints are managed. Records of responses to complaints confirm that this occurs in a timely way and is respectful and comprehensive. When necessary the SRM is involved in complaint management and she reviews all complaints received on her monthly visits.   ARC requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation’s values are on display in the main reception area at Allen Bryant Lifecare (ABL). These are also contained in the business / quality and risk management plan for the facility.   Ultimate Care Group (UCG) is a privately owned company, with a senior leadership team based in their head office in Wellington. There are two regional managers, one each for the North and South Islands. The southern regional manager (SRM) visits each facility she is responsible for at least monthly. She was present during the audit and was interviewed.  The ABL management team is made up of a business manager (BM) and a clinical nurse manager (CNM), who work as a team to manage the entire facility. The business manager has been a caregiver when first employed at the facility 22 years ago and has gradually taken on more responsibility and management functions. She has also completed the three Aged Care Education qualifications of support of the older person (at introductory and higher levels) and the dementia qualification. She was appointed to the role of business (facility) manager 9 years ago. The CNM joined ABL in 2000 as a RN. She left the facility but was asked to return as the CNM 8 years ago. Both the BM and CNM work full time, 72 hours a fortnight and have alternating Fridays off. When they work on a Friday they are also on call over that weekend. When the BM is on call she has another, senior RN on call available for clinical advice.  The BM prepares weekly reports to the SRM, which are then reported through to UCG’s general manager operations (GM Ops). These reports monitor progress against the organisation’s goals, any exceptions to service delivery and clinical indicators (see 1.2.3), occupancy and any maintenance issues.   The SRM and BM report that there is a clear pathway to the chief executive officer (CEO) through UCG’s management structure and GM Ops. There are monthly operations meetings attended by regional managers with the GM Ops. Any issues are reported weekly and discussed monthly. Annual consolidation of data occurs at head office at end of each financial year.   There are position descriptions for each role at ABL including the BM and CNM. Copies of these are on their personnel files. They describe the responsibilities and functions of each role. At interview with the managers and the SRM, all are able to discuss their own responsibilities and how they work with the other roles. The BM and CNM are direct reports of the SRM, who monitors their performance, as well as that of the facility.   ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The BM and CNM provide back-up for one another during a temporary absence. When the BM is on call at the weekends she has the assistance of a senior RN. There are few occasions when both the BM and CNM are away from the facility. In these instances two RNs are rostered on duty during the and another RN on call during the night shift. (Afternoon shifts all have a RN and an EN on duty).   Allen Bryant Lifecare won the UCG award for most improved performer across the group at their 2013 management conference. This award was based on occupancy; meeting their budget; and a range of quality of care measures in use across the organisation. At interview with the general manager operations (GM Ops) he reported that the BM and CNM received the award because they had met these identified measures as well as their performance as a management team for the facility. The SRM confirmed that they consistently meet the measures put in place by UCG to ensure that residents receive safe services.   A review of the weekly report for a random selection of weeks in 2014 demonstrates that the facility continues to achieve their performance measures. At interview with the BM and the CNM, and review of their personnel files, they describe their employment history and ongoing professional development. Both have appropriate skills and knowledge to fulfil their roles, and are supported by UCG.   ARC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an annual quality and risk management plan template which each UCG facility uses as a basis for their quality and risk (Q&R) management plan. The current Allen Bryant Q&R plan is January 2014 – January 2015. There are organisational quality objectives and facility specific quality projects detailed in the plan. The SRM and BM monitor achievement of the objectives through the weekly reporting and the projects through the weekly plan when relevant and the regional manager’s monthly visits to the facility. The SRM reports that the combination of weekly reports, monthly visits and contact in between times enables her to be aware of any emerging issues and to monitor the performance of the facility.  The local quality group at ABL is made up of staff representatives from each area, a cleaner from the housekeeping team, one of the two activities coordinators, the full time cook (Mon – Fri cook) the maintenance person, BM, CNM and another RN. Monthly meetings follow a standard agenda and include collated quality improvement data (see 1.2.4), corrective action follow up, and any quality projects which are underway. Review of meeting minutes during 2013 and 2014 demonstrate that meetings are regular, the standard agenda is followed and progress against the Q&R management plan occurs.   Document control is maintained by the project manager (head office) who ensures that policies are reviewed when required against their review schedule. The clinical governance committee reviews and updates all documents, either as part of the biennially scheduled review, request from a facility for a particular reason and if a revision of the policy, procedure, or document is required ahead of schedule. The business manager is notified of changes by email. These are discussed at the monthly quality group meeting and is in the minutes. A night shift staff member updates the hard copies of each manual. All documents reviewed during the onsite audit are current. Staff interviewed describe the process for maintaining document control within the facility.   There is an annual quality improvement plan which details internal audits and monitoring checks which are to be completed across the yea and the month they are scheduled for. Some internal audits are completed multiple times a year. Review of the 2014 folder shows that all checks occur on schedule as required. Where any corrective action is required this is documented on the quality improvement / corrective action request form. These internal audits cover all aspects of the service and include random sampling of cleaning and laundry effectiveness.  Examples were sighted with the January 2014 hot water monitoring internal audit. Two resident rooms had hot water at over 45 degrees (46 degrees) and immediate action was taken to adjust the tempering valves for these rooms. The QI / CAR form records the implementation of corrective action and how this is monitored.   ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage two: There is an electronic system - GOSH - which is used to enter all quality improvement data / incidents and accidents. These generate graphs of collated data across the year against the organisation’s clinical indicators; falls, skin tears, bruises, medication errors, pressure areas, behaviour and unintentional weight loss.   The quality improvement committee meets monthly and reviews the collated quality improvement data (done by BM). Data is discussed in the context of the previous months’ data and data across the calendar year, types and frequency of events, comparison with similar times in the previous year and discussion of any trends and issues which may be impacting on events. This data is then shared at the monthly staff meeting. Where appropriate, some quality improvement data is shared with residents and family/whanau via the regular newsletter. This is confirmed in interviews with BM, SRM and CNM.   Incident / accident report forms are used to record events. The analysis of event data has determined that falls are the most frequent incident. Medication errors are low with one medication error in August 2013 and one in January 2014. (Medication competency assessment was repeated for the staff member in each case before they were able to be involved in medication administration again.)  The organisation has documented within their quality management system the essential notifications which are required. At interveiw with the BM and SRM they report their understanding of these obligations.   ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage two: The business manager is responsible for ensuring that there are sufficient staff and qualified staff members to meet the needs of residents. Police vetting, references, and interviews are completed. Most new staff are ‘walk-ins’. An application form is completed, BM interviews the person, with the CNM if appropriate and reference checks are completed (two for each prospective employee). When the successful applicant is identified a police check is conducted and once returned a letter of offer and employment agreement are provided and signed. A review of personnel files for 11 staff (including both managers) was completed and this demonstrated that the organisation’s recruitment selection and appointment processes are implemented for all new staff. Longer term staff files were included and these also confirm that a robust process was followed to recruit and appoint these staff.  Professional qualifications for non-clinical staff are recorded on their personnel file through their CV along with a copy of their qualification. Those staff who are health professionals employed by Allen Bryant Lifecare are either RNs or ENs, and the CNM validates their qualifications at appointment and maintains a register of their practising certificates for annual re-verification. Similarly the practising certificates for the two GPs, and the physiotherapist were sighted and are current. The scope of practice for all health professionals is included with their practising certificates.  UCG has an induction / orientation process which is implemented at ABL. This includes a three day programme of induction to the organisation and orientation to the person’s role with additional time allocated for buddy shifts if this is needed. Ongoing training is provided by the organisation following an annual training plan template provided by UCG and implemented at the facility. This incorporates first aid certificates for those staff who are required to hold one, medication competencies, restraint minimisation, infection prevention and control and hand hygiene, and a wide range of other topics relevant to the provision of a health and disability service.   Staff report that there is adequate training for them to stay current in their roles. So far in 2014 there has been: chemical, hazards and the laundry training by Ecolab (12 March), first aid recertification for those who are due, and the comprehensive first aid a new RN, (1 April), Understanding dementia by the dementia nurse at Greymouth Base Hospital, modified diets and swallowing by the speech language therapist at GBH, Wound / continence by the EBos representative, and a session on Parkinson’s disease by the gerontologist from Canterbury DHB. The annual education / update day is scheduled for 12th and 13th May and will cover Code of Rights, advocacy, privacy, informed consent, EPOA, advance directives for resuscitation, complaints, abuse and neglect, cultural and spiritual policies and restraint, intimacy and sexuality communication skills. Across the month there will be four 1 ½ hour sessions on safe patient handling by a local physiotherapist. In June there is a food handling refresher by the hospitality tutor at Greymouth polytechnic and communication skills for residents with swallowing difficulties.   ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage two: Weekly rosters are prepared six weeks in advance. These describe the spread of RN / EN cover on each shift, the caregivers, and a range of ten other non-clinical staff members including the chef / cook, kitchen assistant, maintenance person, activities personnel and housekeeping staff.   There are sufficient staff on each shift to meet the needs of the residents living at ABL. Staff are qualified to undertake their roles and this is confirmed through review of personnel files. Care givers have completed either or both the Aged Care Education (ACE) programme and the National certificate in support of the older person. The BM and the activities coordinator have completed the ACE Dementia training. The RNs and ENs maintain their requirements for professional development.   There are currently four residents who are diagnosed with dementia and who receive care appropriate to their needs. However, they are not funded through the additional funding package for people with dementia. This is confirmed by email with the DHB on the day of the audit. (See also 1.3.1) In the 2013 residents’ satisfaction survey 13 of 14 residents are either very satisfied or satisfied with the nursing care, domestic care and food services at ABL. In the family/whanau satisfaction survey for 2013, 19 responses were received. Across a range of satisfaction measures all respondents were either very satisfied or satisfied with services.   ARC requirements are met. |

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

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

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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:** |
| New admission records reviewed (seven of seven files reviewed including T 1 and T2) have the information recorded on the day of admission or within 48 hours of the resident’s admission. The residents' records contain information to safely identify the residents, are legible signed and dated. There are integrated notes on the residents' progress completed each shift by care staff and if required by the RN (interviewed). Current resident notes are integrated into one file. Residents' records sighted are kept secure in the office when not in use, including current residents’ old notes. Archived files are observed to be stored in the secure roof space, organised and dated for easy retrieval. A signing register reviewed is maintained and includes all staff, GPs and the pharmacist. |

##### **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:** |
| Entry to service documents include an admission package that details all requirements for both parties on admission to the facility. Admission agreements are completed for all residents (seven of seven admission agreements sighted). A needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions (records sighted) to ensure admission is appropriate and on-going annually, for those under a Younger Person’s Disability (YPD) contract.   Residents and family interviewed (including one recent admission) verify the clinical nurse manager (CNM) managed this process in a timely manner, with dignity and respect, taking into account the family and residents’ identified needs.   There is a comprehensive assessment process on admission and on-going to ensure that all the residents identified needs are met (documentation sighted). The admission agreement includes a statement as to when the facility requires a difficult resident to leave the facility, however the facility manager confirms this has not been required.   Residents with dementia - The facility is able to admit residents with dementia as required by the dementia outreach nurse, however there are no residents under this additional funded package at the time of the audit (confirmed in an email from the dementia outreach nurse).  The relevant ARRC requirements are met. |

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

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

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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:** |
| The manager and CNM are interviewed. Documentation sighted verifies the facility will transfer residents who are not suitable to the environment and risks for the resident are managed. There is a record kept (sighted) of those who are declined entry, with timely referral back to the NASC agency. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seven residents' files (four hospital residents and three rest home residents) are reviewed. All those reviewed have an interRAI assessment completed prior to admission, and an initial nursing assessment and a lifestyle care plan developed by the RN. The care plan includes goals and nursing diagnosis, identified needs and interventions in all service areas, including self-care needs, communication, mobility, social needs, including cultural and spiritual, nutrition, continence and behaviour needs.   A short term care plan has been developed if required for skin tears, wounds, mobility issues (falls) and infections (sighted).  Discussion with care staff and observation of a care meetings during the audit, provide evidence that consultation with the RN relating to service provision occurs regularly. Care staff (interviewed) are observed consulting the lifestyle care plan to verify the residents’ care needs. Interview with two of two care staff verifies service provision reflective of the lifestyle care plan content.   The facility has one general practitioner (GP) who visit the residents and these visits are at least twice weekly and as required. The GP is interviewed and confirms the facility provides a high level of care with RN assessments and care staff service provision appropriate and in line with the GP’s recommendations and treatment regime. The GP is involved in the MDT meetings, infection control and restraint minimisation specific to each resident. Emergency services are called appropriately and in a timely manner.  Family contact occurs regularly (family contact forms sighted), either verbally, by phone and as part of the MDT meeting process (initially at three months, then annually).   Tracer 1 (rest home resident) –  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer 2 (hospital resident) –  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  The relevant ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to admission the NASC agency completes an interRAI assessment to ensure that resident placement is appropriate (sighted in files including T1 and T2). The facility RN (interviewed) completes appropriate resident assessments (records sighted) on admission to the facility, including a pressure area risk assessment, falls risk assessment, continence assessment, nutritional assessment, pain and oral assessment. If required a wound assessment is completed. Those reviewed are detailed and comprehensive and are used as the basis of care planning (records sighted).  Those reviewed are completed in a timely manner by the RN. If an issue arises within the three months, an appropriate assessment tool is completed prior to the development of a short term care plan.  The ARRC requirements D16.2 are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seven residents' care plans (four hospital residents and three rest home residents) are reviewed including T1 and T2. The initial care plan is developed following an interRAI assessment and within timeframes to safely meet the resident’s needs. The long term lifestyle care plan is developed within three weeks of admission (records sighted including old notes). When progress alters, the RN (interviewed) will develop a short term care plan, using appropriate assessment tools (documentation sighted).   There is evidence of integration from allied health in the care plans sighted  Three of three care staff interviewed confirm the care plans are easy to follow and are able to describe interventions for T1 and T2 reflective of the care plan. Care staff and the RN and CNM meet late each morning (observed) to discuss care provision that is reflective of the care plan content.   The relevant ARRC requirements are met. |

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

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

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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:** FA |
| **Evidence:** |
| The facility’s RN (interviewed) documents appropriate interventions on the resident's short term or lifestyle care plan. Those sighted are consistent with meeting the resident’s identified outcomes, are evaluated regularly and the care plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents (for example, assistance with mobility after removal of restraint (T2) reflective of the resident’s care plan.  GP assessments sighted are detailed in the appropriate clinical form in the integrated resident's file and the subsequent intervention is included on the resident's short term care plan (sighted).  Residents and family members interviewed confirm service delivery is consistent with meeting the residents' desired outcomes and they are involved in the review process, as evidenced in the family communication form and residents’ MDT team meetings (records sighted).  The relevant ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A social assessment is completed by the family member on admission to the facility (records sighted). The information is included to develop the activity plan.  A monthly group activities programme is developed and provided by the activities person (interviewed) and includes newspaper reading, word find, walks, housie, exercises, van ride, bowls, quiz, crafts and church once a month.  The individual activity plans reviewed do not reflect the resident’s current interests and social activity and are not regularly reviewed. This requires improvement. |

##### **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:** PA Low |
| **Evidence:** |
| A social assessment is completed by the family member on admission to the facility (records sighted). Seven activity plans are reviewed. Those reviewed do not always have a written activity plan that reflects the desired social activity of the resident, as required in ARRC D16.5ciii. For example one resident who attends the gym, and another resident who goes into town for coffee, do not have these regular outings facilitated by the activities person, included in the resident’s activity plans.  Other plans reviewed have not been evaluated and reviewed each time the care plan is reviewed, as required in ARRC D16C iii.  The activity person is interviewed and prepares the activity programme which is repetitive each month, and may not always include enough variety to meet the needs of all residents, although a family member interviewed stated that the activities provided are suitable for her husband.  There are three van trips out each week, and the van can only take six plus one in a wheelchair; however records sighted noted that of those in the van, there are consistently at least the same three residents who go on the outings. The record to identify those who have been asked to go and declined has not been maintained. Three residents interviewed confirmed that the same residents go out each time in the van. |
| **Finding:** |
| Seven activity plans are reviewed. Those reviewed do not always have a written activity plan that reflects the desired social activity of the resident, as required in ARRC D16.5ciii. For example one resident who attends the gym, and another resident who goes into town for coffee, do not have these regular outings facilitated by the activities person, included in the resident’s activity plans.  Other plans reviewed have not been evaluated and reviewed each time the care plan is reviewed, as required in ARRC D16C iii.  The activity person is interviewed and prepares the activity programme, which is repetitive, each month, and may not always include enough variety to meet the needs of all residents, although a family member interviewed stated that the activities provided are suitable for her husband.  There are three van trips out each week, and the van can only take six plus one in a wheelchair; however records sighted noted that of those in the van, there are consistently at least the same three residents who go on the outings. The record to identify those who have been asked to go and declined has not been maintained. Three residents interviewed confirmed that the same residents go out each time in the van |
| **Corrective Action:** |
| Activities are planned and provided to meet the skills, resources and interests of the resident, and are meaningful to the resident and meet the requirements of ARRC D16.5c. |
| **Timeframe (days):** 180 *(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:** FA |
| **Evidence:** |
| The facility's RN is interviewed and seven residents’ files reviewed are evaluated three monthly in line with the facility’s policy (records sighted). Assessments are completed prior to the review of the care plan and the assessment content reflects the updated care plan. The facility also evaluates residents’ care if progress is less than expected using appropriate assessment tools. And a short term plan is developed indicative of the residents' changed needs. T1 and T2 records sighted include short term care plans reflective of their changed needs, and evaluations are included following resolution of these.   Residents and family members interviewed verify they are included in care plan evaluations as part of the MDT process (records sighted) and there is evidence of this also documented in the residents' integrated notes (sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans when needs change.  The ARRC requirements D16.3c; D16.3d; D16.4a are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seven residents’ integrated files are reviewed and the CNM and the RN is interviewed. Two of two files, including T1 and T2, reviewed have evidence of referral to other health and disability services. For example, two external clinician referrals are initiated when a resident has increased needs. Referrals are included in the integrated notes (sighted). There is also evidence in two files of referral to a physiotherapist.   The CNM (interviewed) confirms that, if required, the facility will accompany residents on appointments if the family member is unavailable.  Family and residents (interviewed) provide examples of input from other health and disability services, including the West Coast DHB (WCDHB) outpatient services, and the district nursing service.  The ARRC requirements D16.4c; D16.4d; D20.4 are met. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| One file of a discharged resident is reviewed, and one transfer to and from hospital. The CNM and the manager are interviewed and verify all discharges include the involvement of the resident, family and GP (confirmed in documentation reviewed). A discharge form is completed (sighted) and details any persons involved, any risks and measures to minimise the risk. The file reviewed is completed with evidence of family and GP involvement prior to the discharge, and ensuring the resident’s medications are available following discharge.  The ARRC requirements D21 are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures for medication management are sighted. These detail each health professional’s responsibility in relation to medicine prescribing, administration, reconciliation, allergies, storage, medication errors, antibiotic use, medicine check-in, disposal, short term and pro re nata (prn) medicines, standing orders, non-prescribed approved medication, self-medicating, reconciliation, controlled medicines, pain management, protocol and agreement for supplying medicines and staff competency check forms.   The facility has a blister pack medication system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the RN (records sighted) once per month. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications (records signed by the RN and the pharmacist are sighted).  The resident's prescription medication record is completed by the resident's GP, and administered by the facility care staff. The typed record is legible and each record signed individually by the GP including when discontinued. A carer and an RN are observed administering medications on the day of audit (both have medication competencies - sighted). Records sighted are complete and meet medication guidelines.  The medication trolley holds all current medication, blister packs and medication records and is locked when not in use and stored in the key pad secured medication cupboard.   Controlled drugs are reviewed and storage is in line with guidelines. There is a separate medication fridge, and temperatures are recorded (observed) and within recommended guidelines.  Fourteen medication files are reviewed, including those of T1 and T2. PRN medication is recorded to a level of detail to indicate the intended use, for example for nausea, chest pain, coughing and pain.   There are no residents who self-medicate, although there are policies and procedures and resources in place should this occur.   The ARRC requirements D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are policies and procedures in place for all aspects of food service, delivery, preparation, service, storage and disposal and cleaning (sighted).   A nutritional audit of the menus has been undertaken by a dietitian in 2012 (sighted). The menu content on the day of the audit reflects the version in use by the facility. The menu is altered if the required food stock is unavailable, and the dietitian’ s recommendations are observed to have been implemented.  Dietary profiles are written on admission (seven files sighted), and these include likes and dislikes, preferences for beverages, and any other special dietary instructions. The RN or CNM will inform the kitchen if there are any changes in dietary requirements. Residents' preferences are listed and catered for (verified in resident and family interviews).  Residents and family members interviewed also confirm there is variety in the food provided and it is sufficient and meets their needs. There are no weight issues with residents, and observation of meal service confirms residents enjoy the meal provided.   Meals are prepared and cooked by the chef (interviewed) with the assistance of kitchen staff. Food and fridge temperatures are recorded and those reviewed are within recommended guidelines.   The purchase of food is consistent with menu requirements (sighted), food waste audits are completed monthly (sighted). Storage areas are clean and well maintained.  Food waste is disposed into a bin that is collected daily for pig feed. It is recommended the organisation formalises the agreement as per the MPI (Ministry of Primary Industries) Biosecurity (Meat and food waste for pigs) regulations 2005. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The purchase of food is consistent with menu requirements (sighted), food waste audits are completed monthly (sighted). Storage areas are clean and well maintained, Food waste is disposed into a bin that is collected daily for pig feed, There is no formal agreement in keeping with the guidelines of the MPI (Ministry of Primary Industries) Biosecurity (Meat and food waste for pigs) regulations 2005 and this requires improvement. |
| **Finding:** |
| Food waste is disposed into a bin that is collected daily for pig feed. There is no formal agreement in keeping with the guidelines of the MPI (Ministry of Primary Industries) Biosecurity (Meat and food waste for pigs) regulations 2005. |
| **Corrective Action:** |
| Formalise the agreement related to the collection of food waste as per the current regulations. |
| **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:** |
| The laundry, cleaners’ cupboards (two) and the sluice room have material data safety sheets on the use of cleaning products for specific types of cleaning. There is protective equipment available for the management of waste and hazardous substances. Staff members interviewed report that protective equipment is readily available. There are generous supplies in storage and available for immediate use.   ARC requirements are met. |

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

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

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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:** FA |
| **Evidence:** |
| There is a building warrant of fitness (BWOF) issued on 29 June 2013, expiring 29 June 2014. There is an approved evacuation scheme by the West Coast Fire department dated 22 July 2010. At the last building warrant of fitness notes the biennial inspection of the automatic fire suppression systems in June 2012, and the annual emergency warning systems and backflow preventer and potable water supply.   There is a certificate of safe storage of gas cylinders (for cooking) on 13 March 2014. This is current until 12 March 2017.   The most recent fire alarm and evacuation practice was on 7 May 2013. There was a false alarm activation in November 2013, during which time an evacuation of the affected area was completed until the all clear was given. Because this was around the time of the next scheduled six monthly practice, it was considered to have met the requirements for an evacuation practice. The next sis monthly evacuation practice is on the internal audit/ quality activities calendar for May 2014.  ARC requirements are met. |

##### **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:** 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 1.4.2.4 (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 are adequate numbers of toilets, showers and bathing facilities to meet the needs of the residents at ABL. There are identified visitors and staff toilets which can be easily accessed.   Residents’ toilets, showers and bathing facilities are situated in each of the wings and are in close proximity to the rooms of people who use them.   ARC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bedrooms are of a reasonable size to accommodate residents’ beds, furniture and personal items. Bedrooms are personalised and can accommodate mobility equipment when needed.   There are several larger proportioned rooms which are used by residents who are under 65 with physical disabilities. These residents have large electric wheelchairs which require more space. They are able to easily use their chairs in these larger rooms.   ARC requirements are met. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two dining rooms, one on each wing. A larger dining room has a lounge area at the end of one wing. There are several other smaller, more intimate spaces which can be used by small groups of residents for reading, jigsaws and quiet space. There is a separate lounge with a large screen television which can be used by a large group of residents at any one time.   ARC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a housekeeping team of three staff. Two work week days (one in each ward) and the cleaner on the rest home wing also responsible for the laundry. All laundry is done on site. There are two industrial washing machines and one domestic one for delicate laundering (ie,fine fabrics and wool garments).   There are locked cleaning cupboards which the cleaning and laundry staff have access to and keep secure. Their trolleys have decanted cleaning products, from the bulk supplies in the main cupboard, in labelled bottles.   There are two internal audits which include monitoring of cleaning and laundry – the Safety and Hazard check and the Facility Cleaning check. These are done six monthly on an alternating time frame so that that there is monitoring of cleaning and laundry every three months. These internal audits for 2013 were reveiwed and demonstrate that the cleaning and laundry services are monitored regularly.   Ecolab cleaning and laundry products are used at ABL. The monthly visits by the Ecolab representative include monitoring of these products and the effectiveness of processes. A random sampling of these monthly checks for 2014 were reviewed.   ARC requirements are met. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Alternative cooking – two barbeques, with adequate supplies / gas bottles. Emergency water supply is in 12 x 215 litre header tanks for cooking, washing and toilets. Each person has 3 – 4 litres of bottled water for drinking stored in their wardrobes.   There are civil defence emergency supplies in the roof space which will provide sufficient food for at least three days. There is a civil defence and safety orientation component in the orientation programme. This covers the location of emergency supplies, the location of the Disaster plan and manual and how to shut off mains water and gas. Emergency evacuation procedures are also covered and include the fire equipment, safety systems and responsibilities of staff in an emergency.   The hazard register is reviewed six monthly and updated when necessary with any new hazards. Staff will renew these competencies annually with the fire evacuation practice.   There is a call bell system which has electronic lighted signs which identify which room the assistance is required. During the onsite audit the call bells are observed to be responded to promptly.   ARC requirements are met. |

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

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

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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 1.4.7.3 (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:** |
|  |
| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

##### **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 facility is approximately 25 years old and is of a modern design. All bedrooms have large windows, which can be opened and allow in fresh air. The facility is fresh and air circulates. There are windows in communal areas which can be opened for ventilation.   On the days of audit the facility was a comfortable temperature and residents were observed to be comfortable.   ARC requirements are met. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| UCG has clearly documented policies and procedures which guide the use of restraints in all facilities. The emphasis within this documentation is on the active minimisation of restraint use. All alternatives to restraint use are assessed and explored before any restraint is recommended for an individual resident.   Where enabling equipment is appropriate for a resident, this is done with their consent and promotes independence. Several residents were observed using equipment, to promote their mobility in particular. This was used independently and safely by the residents at all times.   At interview with the facility’s restraint coordinator (who is the CNM) and the BM, they confirm that the organisation’s philosophy of minimising restraint use is promoted at ABL. Resident files reviewed (two of four residents for whom restraints are currently approved) confirm the minimisation of use wherever possible.  ARC requirements are met. |

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

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

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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.)* |

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint approval group in the facility, made up of the CNM who is the restraint coordinator, the GP, one of the RNs and a family representative. (The family representative may change from meeting to meeting, but a family member of a resident who currently uses a restraint is always present in the approval group.) The group meets six monthly to approve / validate the restraints in use at the facility and to undertake a review of the restraints in use for each resident.   The organisation’s clinical governance group reviews the policies and procedures for restraint use. The SRM also reviews the restraint register on her monthly visits.  Once a restraint is approved for a resident, its use of restraint, or the discontinuation of use, is recorded in the restraint register. The policies and procedures clearly describe the process for approval of any restraint and the role of the approval group. Analysis of all records related to restraint use demonstrates that the approval process is well implemented in the facility.   The register was reviewed during the onsite audit. It is current and there are four people with restraints (which are lap belts) in use. All have an appropriate assessment involving the GP, CNM with care team input , and consent from family/whanau.  ARC requirements are met. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Assessment is by the GP in consultation with CNM and care team. The assessment form in use is a combined assessment tool and consent form. All four residents with restraints in use have a consent form and assessment of need has been completed by the GP and CNM following the organisation’s process.   Review of the restraint register also demonstrates that were use of restraint does not promote safety it is discontinued immediately. The most recent example is a resident whose family requested and consented to the use of bed rails to try to limit ‘falls’ from bed overnight. The assessment and approval process records the discussion that the use of bed rails may be contra-indicated for the resident however these were trialled. When it was demonstrated that the resident was still able to get out of bed during the night, their use was discontinued.   The resident’s file records the use of alternatives (lowering the bed, a sensor mat, additions to the care plan) used instead and the effectiveness of this protocol. The assessment for the use of the restraint also records the discussion of the potential risks, the contra-indications for the use of the restraint and risk management strategies, and the alternatives which were recommended by the CNM.   ARC requirements are met. |

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

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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.)* |

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

Services use restraint safely

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| At interview with the CNM / restraint coordinator she reports that the practice in the facility is of restraint use as a last resort. The process for approval and assessment guides staff to consider all possible options. The restraint coordinator describes the involvement of all care staff in gathering information. When in use the restraint is unobtrusive and ensures safety.   A register is maintained which is current and includes current status of the restraints (four) in use at ABL. Over the past year the only restraint used which did not promote safely was immediately discontinued. (See standard 2.2.2).  The files for two of the four residents’ with restraints were reviewed during the stage two audit and demonstrate that the restraints are safe and minimise harm. The approval group adheres to the organisation’s systems for the use of restraints and family involvement is promoted as part of the restraint approval group.  ARC requirements are met. |

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

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

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

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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.)* |

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All use of restraint (lap belts) is monitored hourly and each person with an approved restraint has this evaluated on a three monthly basis. Copies of these 3 monthly evaluations are maintained with the restraint register. These demonstrate a thorough process of evaluating use for each individual very regularly.   Challenging behaviour training was held in February 2014 with two more sessions scheduled for May to repeat this and ensure all staff attend.   Restraint use is reported at the Quality Committee meetings and the staff meetings each month. Quality improvement and staff meeting minutes record consistently the evaluation of restraint use.   ARC requirements are met. |

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint use is reported at the Quality committee meetings and the staff meetings each month. Quality improvement and staff meeting minutes record consistently the evaluation of restraint use. At her monthly visits to the facility the SRM also reviews the restraint register and meeting minutes.   At interview the CNM reports that the GP is available and is involved in the review of all restraint use, as well as individual assessments. The six monthly restraint approval group meetings are extremely regular and occur in a timely way. Meeting minutes always record a discussion of overall restraint use. The CNM also describes the ability to contribute to the organisation’s review of restraint use through the regular visits by the SRM who is a member of the UCG clinical governance group who also oversees restraint use.  ARC requirements are met. |

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:  
(a) The extent of restraint use and any trends;  
(b) The organisation's progress in reducing restraint;  
(c) Adverse outcomes;  
(d) Service provider compliance with policies and procedures;  
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  
(g) Whether changes to policy, procedures, or guidelines are required; and  
(h) Whether there are additional education or training needs or changes required to existing education.

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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.)* |

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection control policies and procedures define the responsibility for infection control and the link to the quality meetings and organisational management. The infection control (IC) programme is reviewed annually (sighted) with clear lines of accountability and this is approved by the manager. All requirements of the IC standard are included. The CNM, who is the IC co-ordinator (job description sighted), collates all data monthly, providing a summarised report at the quality meeting (meeting records sighted). There is a report provided to staff and care staff interviewed are able to demonstrate their knowledge on observing, reporting and documenting infections.  The facility's front entrance notice requests persons with ‘flu’ not to visit and hand gel is available at the front door and throughout the facility for any visitor or resident to use. Visitors are observed using the hand gel. If there are any internal infections, the facility has processes in place to prevent visitors and to isolate the infection.   The ARRC requirements D5.4e are met |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The CNM is the IC co-ordinator with experience and on-going training in IC (records sighted). The CNM documents resident specific IC information, including treatments and conclusions, reporting results to the quality meeting monthly (records sighted). The quality meeting consists of the facility manager and a RN. A report is included in the agenda for monthly staff meetings (minutes sighted).  Expert advice is gained from the West Coast DHB and the resident’s GP as required for any resident with an infection (confirmed in GP interview). Residents and family interviewed verify they are advised of infections and treatments. Observed throughout the facility is hand gel and soap dispensers and education on hand hygiene on walls above hand basin. The facility has an up to date outbreak kit (sighted). There have been no reported outbreaks of infections. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is suite of infection control policies and procedures that are aligned to the organisation and fit for purpose for UCG Allen Bryant (sighted). Examples of these include precautions for infections that are airborne, droplet and contact transmission-based; pets and pest control, personal protective equipment, outbreak management, notifiable diseases and all others as listed in (a) to (i) of this criteria. The IC co-ordinator (interviewed) uses the Bug Control manual as a reference to ensure policies meet best practice guidelines. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The CNM is experienced in IC and is able to provide on-going education for staff. The CNM attends an annual Bug Control update day (records sighted). IC education is provided initially on induction (eight staff files reviewed), and then annually as part of the internal education programme (records sighted).  Care staff interviewed confirm their participation in IC training and demonstrate IC practices (observed). A notice at the front entrance and above communal hand basins provides visual aid in the correct hand hygiene methods (sighted). |

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

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

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

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

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

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

#### 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:** |
| A form for the purpose of collecting monthly data on all infections is maintained by the CNM. The information is transferred to an organisation wide electronic data analyses sheet (sighted), listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections.  Documentation sighted includes the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections.  Evidence in the last two quality meeting minutes and staff meeting minutes verify that IC surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the organisation. |

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

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

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

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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.)* |