

# Age Care Central Limited - Maryann Rest Home

---

Current Status: 17 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

Aged Care Central Limited is a company formed to manage the operations of Maryann rest home and hospital, and Marire rest home (sister rest home). Maryann rest home and hospital is owned by Taranaki Electricity Trust Holdings Ltd. Age Care Central Ltd is registered as a charitable entity under the Charities Act. The chief executive officer (CEO) and three directors form the Board, have a governance role for the two sites.

Maryann rest home and hospital provides care for up to 48 residents at rest home, dementia and hospital level care. At the time of the audit, there were 43 residents including, 13 residents receiving dementia level care, 13 rest home level care and 17 receiving hospital level care. Current capacity in the dementia unit is 16 beds. There are two additional rooms that can also be added to the unit from the hospital wing.

Appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff. The nurse manager is an experienced registered nurse with many years of experience in practice nursing, nursing education and managing aged care facilities. She is also supported by two clinical coordinators.

The service is commended for achieving a continual improvement rating around recognition of Maori beliefs and values.

The audit identified improvement requiring around aspects of training, medication management, aspects of care planning, and documentation of advanced directives.

## Audit Summary as at 17 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

Indicator	Description	Definition
	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 17 March 2014

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

#### Organisational Management as at 17 March 2014

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

#### Continuum of Service Delivery as at 17 March 2014

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

#### Safe and Appropriate Environment as at 17 March 2014

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

## Restraint Minimisation and Safe Practice as at 17 March 2014

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 17 March 2014

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

## Audit Results as at 17 March 2014

### Consumer Rights

Maryann complies with the code of rights. There are policies and procedures related to resident's rights and they are current and reflect the understanding of the Code. Residents/relatives are informed concerning the code of rights. Staff are educated ensuring knowledge of consumer rights. Maryann committed to ensuring that residents who identify as Māori to their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services. Maryann has two residents that identify themselves as Maori. An interview with a cultural adviser and the whanau of a Maori resident confirmed satisfaction with the service around individual needs of Maori. Complaints processes are implemented, complaints, and concerns are actively managed and well documented. The audit identified an improvement requiring around documentation of advanced directives.

### Organisational Management

There is a business plan 2012-2015 that includes mission statement, vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed and this includes key performance indicators and progress against goals. The business plan also includes dementia specific goals. The quality management plan is implemented. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman and as needed. There is a comprehensive health and safety and risk management programme. There is a nurse manager who covers both site of the business. She is supported by two clinical coordinators. There are minimum four hours a week or as required registered nurse input to the dementia unit. Maryann has well developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service including residents that require rest home, hospital and dementia level care.

There is comprehensive orientation programme that provides new staff with relevant information for safe work practice. All registered nurses maintain professional development portfolio and 81% of staff have a national qualification in care of elderly. An on-going training is provided to staff around dementia by Midland regional dementia behavioural support advisory coordinator. All caregivers who work in the dementia unit have completed or are in the process of completing their required dementia standards.

There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. Staffing roster is sighted and there is staff on duty to match needs of different shifts. There is an improvement requiring around continence management training.

### **Continuum of Service Delivery**

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. There is an improvement required for long-term care plans. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly. Wound management plans are in place. The diversional therapist and activities coordinators provide an activities programme for the residents that is varied, interesting and involves the families/whanau and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. There needs to be an improvement required to ensure that the residents have medications reviewed three monthly and that the GP signs this off and that 'as required' medication has a frequency charted. Meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents, family/whanau interviewed responded favourably to the food that was provided.

### **Safe and Appropriate Environment**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. Hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

## **Restraint Minimisation and Safe Practice**

The restraint policy includes comprehensive restraint procedures. There is a documented definition of restraint and enablers. There is a restraint register, which also records residents who require the use of an enabler. The restraint register is current. Approved restraint is reviewed at least three monthly.

Restraint approval process is undertaken, where relevant, with the resident and family, other health professionals and specialists. All restraint is approved by the general practitioner and the restraint coordinator. Restraint consent form is signed by all parties. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. There are eight residents with restraint in the hospital. There are two residents using a lap belt as an enabler and they signed consent form for use of this. All required documentation for restraint and enabler use is recorded in the restraint folder.

## **Infection Prevention and Control**

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is one of the clinical coordinators who is responsible for all infection control and prevention activities, surveillance and coordinating/providing education, and training for staff. The infection control policies and procedures are reviewed in 2013 and these are current and comply with standards legislation and guidelines for infection control practises. The service also purchased Bug Control 2014 Infection Control Manual. All staff are involved in the implementation of policies. Staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme.

# 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

<b>Legal entity name:</b>	Age Care Central Limited		
<b>Certificate name:</b>	Age Care Central Limited - Maryann Rest Home		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Maryann Rest Home and Hospital		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care		
<b>Dates of audit:</b>	<b>Start date:</b> 17 March 2014	<b>End date:</b> 18 March 2014	
<b>Proposed changes to current services (if any):</b>	Maryann proposes two swing beds in the dementia unit to meet community needs if required. Currently these two rooms are outside the secure door and utilised as a hospital room. These can be added in to the dementia unit by a second secure door, which is already set up but is not activated yet. These two rooms are identified as suitable for either hospital or dementia level care.		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			43

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	7
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	16	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	

## Sample Totals

Total audit hours on site	32	Total audit hours off site	12	Total audit hours	44
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	5
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	5
Number of medication records reviewed	14	Total number of staff (headcount)	52	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	3			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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Monday, 5 May 2014

## Executive Summary of Audit

### General Overview

Aged Care Central Limited is a company formed to manage the operations of Maryann rest home and hospital, and Marire rest home (sister rest home). Maryann rest home and hospital is owned by Taranaki Electricity Trust Holdings Ltd. Age Care Central Ltd is registered as a charitable entity under the Charities Act. The chief executive officer (CEO) and three directors form the Board, have a governance role for the two sites. Maryann rest home and hospital provides care for up to 48 residents at rest home, dementia and hospital level care. At the time of the audit, there were 43 residents including, 13 residents receiving dementia level care, 13 rest home level care and 17 receiving hospital level care. Current capacity in the dementia unit is 16 beds. There are two additional rooms that can also be added to the unit from the hospital wing. Appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff. The nurse manager is an experienced registered nurse with many years of experience in practice nursing, nursing education and managing aged care facilities. She is also supported by two clinical coordinators. The service is commended for achieving a continual improvement rating around recognition of Maori beliefs and values. The audit identified improvement requiring around aspects of training, medication management, aspects of care planning, and documentation of advanced directives.

### Outcome 1.1: Consumer Rights

Maryann complies with the code of rights. There are policies and procedures related to resident's rights and they are current and reflect the understanding of the Code. Residents/relatives are informed concerning the code of rights. Staff are educated ensuring knowledge of consumer rights. Maryann committed to ensuring that residents who identify as Māori to their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services. Maryann has two residents that identify themselves as Maori. An interview with a cultural adviser and the whanau of a Maori resident confirmed satisfaction with the service around individual needs of Maori. Complaints processes are implemented, complaints, and concerns are actively managed and well documented. The audit identified an improvement requiring around documentation of advanced directives.

### Outcome 1.2: Organisational Management

There is a business plan 2012-2015 that includes mission statement, vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed and this includes key performance indicators and progress against goals. The business plan also includes dementia specific goals. The quality management plan is implemented. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman and as needed. There is a comprehensive health and safety and risk management programme. There is a nurse manager who covers both site of the business. She is supported by two clinical coordinators. There are minimum four hours a week or as required registered nurse input to the dementia unit. Maryann has well developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service including residents that require rest

home, hospital and dementia level care.

There is comprehensive orientation programme that provides new staff with relevant information for safe work practice. All registered nurses maintain professional development portfolio and 81% of staff have a national qualification in care of elderly. An on-going training is provided to staff around dementia by Midland regional dementia behavioural support advisory coordinator. All caregivers who work in the dementia unit have completed or are in the process of completing their required dementia standards.

There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. Staffing roster is sighted and there is staff on duty to match needs of different shifts. There is an improvement requiring around continence management training.

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

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. There is an improvement required for long-term care plans. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly. Wound management plans are in place. The diversional therapist and activities coordinators provide an activities programme for the residents that is varied, interesting and involves the families/whanau and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. There needs to be an improvement required to ensure that the residents have medications reviewed three monthly and that the GP signs this off and that 'as required' medication has a frequency charted. Meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents, family/whanau interviewed responded favourably to the food that was provided.

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

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service provider's documentation evidences appropriate systems are in place to ensure the consumers' physical environment and facilities are appropriate for their purpose. Buildings, plant and equipment comply with legislation. Hot water temperatures are being monitored and recorded on a regular basis. Internal and external areas are safe for residents and family/whanau members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources, an appropriate call bell system and security systems are in place.

### **Outcome 2: Restraint Minimisation and Safe Practice**

The restraint policy includes comprehensive restraint procedures. There is a documented definition of restraint and enablers. There is a restraint register, which also records residents who require the use of an enabler. The restraint register is current. Approved restraint is reviewed at least three monthly. Restraint approval process is undertaken, where relevant, with the resident and family, other health professionals and specialists. All restraint is approved by the general practitioner and the restraint coordinator. Restraint consent form is signed by all parties. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. There are eight residents with restraint in

the hospital. There are two residents using a lap belt as an enabler and they signed consent form for use of this. All required documentation for restraint and enabler use is recorded in the restraint folder.

### Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is one of the clinical coordinators who is responsible for all infection control and prevention activities, surveillance and coordinating/providing education, and training for staff. The infection control policies and procedures are reviewed in 2013 and these are current and comply with standards legislation and guidelines for infection control practises. The service also purchased Bug Control 2014 Infection Control Manual. All staff are involved in the implementation of policies. Staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	1	45	0	3	1	0	0
<b>Criteria</b>	1	95	0	4	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	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 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		consent.				
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	In two of seven residents files sampled the informed consent for medications was not signed.	Ensure all consents are signed.	60
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Two of seven resident files contained advance directives, which had been signed off by family/whanau.	Ensure all advance directives are signed by the resident (deemed competent).	60
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Staff did not receive training around continence management in the last two years. Individual training records are not monitored ensuring that all staff receive minimum eight hours training a year.	Ensure that staff receive training around continence management and staff training records are maintained.	180
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		desired outcomes.				
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	One resident with type two diabetes and is on insulin did not have instructions for management of diabetes or blood sugar monitoring reflected in their long term care plan.	Ensure that all residents with diabetes have instructions for the management and monitoring of diabetes identified in the LTCP	30
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	i) Five out of 14 medication charts do not have a signed off three monthly review by the GP. ii) Three of 14 charts sampled did not have the frequency of 'as required' drugs documented.	i) Ensure medication review occur three monthly. Ensure the three monthly reviews have been signed off. (ii) Ensure the 'as required' meds have a frequency charted by the GP.	30

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.4: Recognition Of Māori Values And Beliefs	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.	CI	
HDS(C)S.2008	Criterion 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.	CI	Several efforts made to ensure that Maori consumers have access to appropriate services. These include but not limited to: 1) The service developed Maori health plan that identifies the needs of the region and was approved by the directors of the board. The Maori health plan also includes Maori health priorities action plan, and has 10 objectives around staff preparedness and improving access to services for Maori. The CEO advised that the plan will be reviewed in June 2014. 2) There is also a Maori health policy that refers to Te Kawau Maro, Taranaki Maori Health Strategy 2009 to 2029. 3) The nurse manager had obtained a qualification regarding Maori history and understanding of Maori culture. 4) CEO is Kaumataua. 5) Branding of organisation as Aged Care Central Ltd includes Maori themes. 6) The organisation structure also includes cultural and spiritual advisors of Maori. 7) There is a whanua room and a separate room with a kitchenette for use of Maori residents and whanau. Staff gave examples of how these facilities are utilised during a palliative care to a Maori resident. 8) A large print of the code is displayed at the front entrance and it is in Maori. 9) An interview with a cultural adviser and the whanau of a Maori resident confirmed satisfaction with the service around individual needs of Maori. 10) All RN's have PDRP portfolios that include competencies around Treaty of Waitangi.

# 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The code of health and disability rights is incorporated into care. Training was last provided on the code of rights and advocacy on January 2014. Code of rights is also included in the orientation program for new staff. Discussions with five caregivers (two dementia unit, three rest home/ hospital) identified their familiarity with the code of rights. A review of care plans, staff and management meeting minutes and discussion with eight family members (two-dementia unit, two rest home and four hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.

### 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.

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

Code of rights leaflets are available at the front entrance of the service. The information pack for new residents/families on entry includes information about the code of rights. Large print of Health and Disability Code of Rights posters are on the walls in the entrance. The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, clinical coordinators or registered nurses discuss the information pack with the resident and their family/whānau. This includes the code of rights, complaints and advocacy information. Discussions with eight family members (two-dementia unit and two rest home and four hospital) identified that they are well informed about the code of rights and access to advocacy services. The service provides an open-door policy for concerns or complaints. Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. This information is also provided prior to entry to the service as part of the information booklet. Discussions with five caregivers (two-dementia unit and three rest home/hospital) identified that they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has an elder protection policy and includes definitions and examples of abuse and neglect. Elder protection is also included in the staff orientation programme. Staff / resident interaction was observed to be appropriate during the audit. Five caregivers interviewed were aware of the types of abuse and neglect and their responsibilities in reporting any concerns. Discussions with three registered nurses, two clinical coordinators and five caregivers identify that there is a strong culture of reporting.</p> <p>Eight family members (two dementia unit and two rest home and four hospital) interviewed stated that they have not seen any incidences of elder abuse and neglect and staff are very caring and respectful. Elder protection training was last delivered in October 2013.</p> <p>The service obtains day-to-day consent of residents when providing personal care. Care planning accommodates individual choices of residents and/or their family/whanau.</p> <p>D4.1a All seven resident files reviewed (two dementia unit and three hospital and two rest home) identified that cultural and/or spiritual values and individual preferences are identified.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement e.g. management of valuables and money. Seven files reviewed included a property list.</p> <p>E4.1a Two families from the dementia unit interviewed stated that their family members were welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.</p>

**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.

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> CI
<b>Evidence:</b> <p>Maori health guidelines are in place to support Maori residents and whanau. The importance of whanau is identified in policy. The service has a linkage to a local Maori advisor. There are two Maori residents. Cultural, social, spiritual and emotional needs are identified in residents' care plans. Staff stated that whanau are actively involved in residents' care and support. Staff identified how they would obtain further cultural support if required.</p> <p>The service have a family/ whanau room and separate room with a kitchenette within hospital wing. Staff advised that the whanau room is used recently by a family who were able to stay for four days and nights to be with their mum during the last stages of her life. Mattresses were placed on the floor and as many as 20 people were able to rest during their vigil.</p> <p>The service have relationships with Maori Women's Welfare League. Ngati Ruanui Tahuna. Tui Ora Maori Services.</p>

Maryann achieved a continual improvement rating in recognition of Maori values of beliefs.

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

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

**Attainment and Risk:** CI

**Evidence:**

Document review and interview with management and the staff confirm that Maryann is committed to ensuring that residents' who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their cultural values and beliefs. They recognise the uniqueness of Māori and Māori values and beliefs during service provision and they actively work to remove barriers to access to their services.

**Finding:**

Several effort made to ensure that Maori consumers have access to appropriate services. These include but not limited to: 1) The service developed Maori health plan that identifies the needs of the region and was approved by the directors of the board. The Maori health plan also includes Maori health priorities action plan, and has 10 objectives around staff preparedness and improving access to services for Maori. The CEO advised that the plan will be reviewed in June 2014. 2) There is also a Maori health policy that refers to Te Kawau Maro, Taranaki Maori Health Strategy 2009 to 2029. 3) The nurse manager had obtained a qualification regarding Maori history and understanding of Maori culture. 4) CEO is Kaumataua. 5) Branding of organisation as Aged Care Central Ltd includes Maori themes. 6) The organisation structure also includes cultural and spiritual advisors of Maori. 7) There is a whanua room and a separate room with a kitchenette for use of Maori residents and whanau. Staff gave examples of how these facilities are utilised during a palliative care to a Maori resident. 8) A large print of the code is displayed at the front entrance and it is in Maori. 9) An interview with a cultural adviser and the whanau of a Maori resident confirmed satisfaction with the service around individual needs of Maori. 10) All RN's have PDRP portfolios that include competencies around Treaty of Waitangi.

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The assessment process enables appropriate responses to individual cultural beliefs. Initial and on-going assessments include gaining details of people's culture, beliefs and values. ACE training covers cultural awareness and 80% of staff have ACE qualification.

Information about resident's beliefs and values is gathered on admission with family involvement and is integrated with the residents care plans. Regular reviews are evident and the involvement of family/whanau is recorded in the resident's care plan.

Cultural safety policies and Maori health plan reflect culturally safe practices and access to appropriate expertise e.g. cultural advisors.

Care plans include cultural values & beliefs, desired outcome or goals. Care plans document support and interventions to meet the resident's needs, individual preferences and chosen lifestyles.

The service establishes links with family/whanau or other appropriate representatives as required. Family meetings occur at admission and it is on-going then after.

Clinical coordinators and registered nurses contact families when required. Eight family members (two dementia unit, two rest home and four hospital) and five residents (two rest home and three hospital) confirm that they are consulted regarding individual values and beliefs.

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Staff are made aware of the code of conduct at induction. There are house rules in the collective and individual agreements. Any concerns with professional boundaries are raised at the RN and caregiver meetings. The service has clear policies and house rules on professional standards and the conduct expected of staff. Five caregivers, three registered nurses interviewed were aware of maintaining professional boundaries, and stated that they would report any breaches if this was evidenced.</p> <p>The nurse manager stated that complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. A review of the accident/incident reporting system and staff interview indicates there have been no staff infringements involving professional misconduct. Job descriptions detail professional responsibilities and boundaries. Performance reviews and staff progress tracking sheets are used for monitoring individual staff adherence to professional standards. Enrolled nurses work under the direction and supervision of registered nurses.</p> <p>Consumer satisfaction survey 2013 showed total satisfaction in areas of rights, privacy, and nursing care. Resident and family interview confirms no incidences of discrimination, coercion, harassment, sexual, financial or, other exploitation.</p>

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> A2.2 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff communication is maintained and kept up to date verbal handovers, written handovers, and memos, reading folders, diaries, e mails and regular team meetings. A quality monitoring programme is implemented and this monitors contractual requirements and standards compliance and the quality of service delivery. The internal audit schedule is implemented and consumer surveys are conducted. Five residents and eight family members interviewed spoke very positively about the care provided. D1.3 all approved service standards are adhered to. D17.7c There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

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

### 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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term residential care in a rest home or hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii: Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>D16.4b: The seven family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising. Resident meetings occur four times a year and the nurse manager has an open-door policy. There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Consumer satisfaction survey 2013 shows satisfaction with communication of staff.</p> <p>Review of incident and accident forms show that following of an event families are notified. Registered nurses interview stated that families often give instructions to staff regarding what and when they would like to be contacted should an accident of a certain type, and this is documented in the resident files. Family interview confirm that this occurs.</p> <p>Discussions with five caregivers (three rest home/hospital and two dementia) identified that they have sufficient time to talk with residents.</p> <p>Interviews with residents and family members confirmed effective communication and open disclosure. Staff wear name badges for identification. The service has policies and procedures available for access to interpreter services. On interview, staff described how this occurs.</p> <p>Document review showed evidence around family communication and links with family/ whanau via email, phone calls, person to person.</p> <p>D11.3 The information pack is available in large print and the audit team was advised that this can be read to residents.</p>

**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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families/whanau on admission. This is also discussed with residents and their families during the admission process. Five caregivers (two dementia, three hospital/rest home) interviewed are familiar with the code of rights and informed consent when delivering resident cares and that consents are sought in the delivery of personal cares. This is confirmed by four residents (two rest home, two hospital). Code of rights and informed choice training completed January 2014. In two of seven resident files, the medication informed consent was not signed. This is an area for improvement. There is a policy on advanced directive, which clearly includes who may sign the advance directive. Advance directives are in place for resuscitation status in seven of seven files. In two of seven resident files (one rest home, four hospital, two dementia) sampled the advance directive was signed by a family/whanau member. This requires improvement. Eight family/whanau (four hospital, two rest home, two dementia), four residents (two hospital, two rest home) were aware of advocacy services and how to access the service. All caregivers interviewed confirmed the process for advocacy.  
D3.1.d: Discussion with eight family/whanau members identifies that the service actively involves them in decisions that affect their relative's lives.  
D13.1: There were seven of seven signed admission agreements sighted.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

In two of seven residents files sampled the informed consent for medications was not signed.

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is an informed consent policy that includes responsibilities and procedures for staff. Information on informed consent is provided and discussed with the resident and family/whanau on admission. Staff interviewed is familiar with the code of rights and informed consent. Residents confirm that consent is sought when cares are being delivered.
<b>Finding:</b> In two of seven residents files sampled the informed consent for medications was not signed.
<b>Corrective Action:</b> Ensure all consents are signed.
<b>Timeframe (days):</b> 60 (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is a policy on advance directives that clearly indicates who can sign the advanced directive. Advance directives are in use.
<b>Finding:</b> Two of seven resident files contained advance directives, which had been signed off by family/whanau.
<b>Corrective Action:</b> Ensure all advance directives are signed by the resident (deemed competent).
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The right to access advocacy services is identified for residents/families. There is an advocacy and consumer support policy in place. Leaflets are available at the entrance. The information identifies who to contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.

D4.1e; The resident file includes information on residents family/whanau and chosen social networks with details of any contacts documented in the family/whanau contact sheet.

D4.1d; Discussion with eight family members (two dementia, two rest home and four hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D3.1.e Interviews with an activity staff described how residents are supported and encouraged to remain involved in the community and external groups. Maryann's activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility. There are visiting groups that regularly visit Maryann. The residents are encouraged to maintain familiar links with outside groups such as churches and service organisations. Regular church services are held for those residents who wish to attend. Entertainers are employed to visit for regular activities. The service encourage friends and family contact at any time. There are no restrictions on visiting, taking residents for outings. There is a whānau room for family gatherings to take place and encouraged the celebration of special occasions.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D13.3h. There is a complaints policy that complies with Right 10 of the Code. Residents and their family/whanau are provided with information on the complaints process on admission. Complaint forms are available at the entrance to the service. Staff are aware of the complaints process and to whom they should direct complaints. Eight family members interviewed (two rest home, four hospital and two dementia) confirm their awareness of the complaint process for the service, and they have been provided with information regarding making a complaint. There were nine complaints registered between October 2013 to February 2014. All complaints are managed appropriately, and all documentation including acknowledgement letters, investigation reports and follow up letters are maintained in the complaint folder. Complaints are managed in a sensitive manner, and a corrective action plan is developed as appropriate. Documentation shows that complainants have been informed regarding progress of investigation and/or outcome of investigation.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Aged Care Central Limited is a company formed to manage the operations of Maryann rest home and hospital and Marire rest home. Maryann rest home and hospital is owned by Taranaki Electricity Trust Holdings Ltd. Age Care Central Ltd is registered as a charitable entity under the Charities Act. The CEO and three directors form the Board, which takes a governance role for the two sites. The CEO has background in radiography and he is also the Mayor of Stratford.

There is a business plan 2012-2015 that includes a mission statement, and vision and goals around governance, financial management, clinical management, people management and asset management. The business plan has been reviewed on 30 November 2013 and this includes key performance indicators and progress against goals. Business plan also includes dementia specific goals.

There is an organisation quality management plan 2014-2015, which includes marketing and publicity, human resources, consumer rights, restraint minimisation and safe

practice, medicine management, clinical management, diversional therapy, document control, housekeeping, food services, health and safety and infection control. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contact with the chairman or as needed. There is a nurse manager who covers both side of the business. She is supported by two clinical coordinators. There is minimum four hours a week or as required RN input to the dementia unit. There is also domestic services manager who is responsible of managing non-clinical side of the business.

Maryann rest home and hospital provides care for up to 48 residents at rest home, dementia and hospital level care. At the time of the audit, there are 43 residents including 13 residents receiving dementia level care, 13 rest home level care and 17 receiving hospital level care. Rest home has eight beds capacity and five of rest home residents are residing in the hospital. Dementia unit current capacity is 16 beds and two additional rooms that can also be added to the unit from the hospital wing. There is an additional secure door that can be activated if these rooms are occupied. The audit identified that these two rooms are suitable for providing either hospital and /or dementia level care.

D15.3d: The nurse manager has annually maintained at least eight hours of professional development activities related to managing a rest home. The nurse manager was appointed to her role in April 2013 and she is a NZRN. She has worked as a practise nurse for eight years, a district nurse for nine years and as a nurse tutor for 12 years. She was previously running another aged care facility in Levin.

E2.1 The business plan also includes providing safe and therapeutic care for residents with dementia.

**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.

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

### 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  In the absence of the nurse manager who has clinical oversight for both Maire and Maryann, two clinical coordinators fulfil the role at Maryann. They are supported by the CEO in non-clinical matters. Clinical coordinators are both experienced RNs with current PDRP portfolio.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

Maryann rest home and hospital implements its quality and risk management system. Key components of the quality system link to service delivery. Quality data is reported at the risk management meetings. Discussions with three registered nurses, two clinical coordinators and five caregivers (two dementia and three rest home and hospital) and review of meeting minutes demonstrate their involvement in quality and risk activities. Registered nurse meetings and caregiver's forum include discussions relating to the components of the quality and risk activities.

Resident meetings are held four times a year and minutes are maintained. Resident survey was last completed in 2013, which shows satisfaction with the services provided. Review of meeting minutes and follow ups from the survey show quality initiatives around food and laundry services.

There are several other meeting such as senior management meetings twice monthly, RN meetings at least five times a year, two monthly Board meetings, health and safety and infection control meetings three times a year, food services meeting four times a year, and housekeeping and maintenance meeting are held four times a year. The management meeting agenda and the staff meeting agenda include (but not limited to complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, education, quality activities, policies and procedures and general business. Minutes are maintained and kept in the staff reading folder as well as meeting minute's folder. Clinical audits are completed by the nurse manager and non –clinical audits are completed by the domestic services manager. Several quality improvement plans/action plans are being developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement. Such as tea, meals are used to be prepared earlier, and heated and served at tea times. Now, meals are prepared fresh just before serving. Insulated plates for the dementia unit has been purchased following an issue around meal temperatures.

Short term care plan audit was last completed in November 2013. Following the audit, corrective actions are implemented and signed off. Medication audits are completed in August 2013 and then follow up audit compliance of medication management system occurred in November 2013. All staff who are medicine competent maintain current competency. Five caregivers interviewed confirmed several spot checks during medication administration throughout the year.

There is a document control system. All policies include the date the policy was last reviewed. Documents no longer relevant to the service are removed and archived. Discussion with five caregivers and three registered nurses identified that staff are familiar with the policies and procedures.

There are implemented health and safety policies that include hazard identification. Domestic services manager is the health and safety officer. A review of the documentation indicates that maintenance issues and hazards are resolved promptly. Hazard register is up to date and the last entry was dated January 2014.

There is an annual staff training programme that is implemented, however staff have not completed continence management training. See CAR 1.2.7.5.

81% of staff hold a national qualification in care of elderly and all registered nurses have a PDRP portfolio.

D5.4: The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are infection control policies and procedure and a restraint policy and health and safety policies and procedures.  
 D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.

**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.

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incidents/accidents and near misses are investigated and a log of incidents occurs monthly. There is a discussion of incidents/accidents at quarterly risk management meetings and caregiver and RN meetings. Statistics of accidents/incidents are published monthly. Staff and resident incident accident forms are recorded separately. D19.3c Discussions with the nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>25 incident/accident forms reviewed for January 2014 and included all areas of the services (12 hospital, five rest home and eight de mentia). In all cases, a post incident follow up was completed by a registered nurse. Three of these incidences led to changes in care planning. One resident with high falls risk had a new risk management plan and was transferred closer to the nurse's office. Another resident with several falls incidences when he was using his scooter, re-assessed by the GP. Then, following a family meeting, his scooter has been removed as identified not safe for the resident to use. Another resident's care plan is updated following a falls incident to "two person assistance" at all times. All five incident reports from the dementia unit had a comprehensive assessment completed by an RN and incident and accidents reports described preventable actions</p>

plans.

The five caregivers and three registered nurses interviewed are all familiar with the incident/accident reporting process and describe discussion of these at the caregiver's forum. A copy of the incident and accident monthly report included in the staff reading folder. Handover process includes reports related to incident and accidents.

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are job descriptions for each position and appropriate human resource policies/procedures are implemented including staff recruitment and support. Staff orientation programme is established and implemented. Staff performance appraisals are completed 2-3 times a year to give staff timely positive feedback and performance corrections as needed. Evidence of reference checking sighted in the files. All registered nurses employed have current PDRP portfolio. Three of the RNs are work place assessors. All caregivers are supervised by a registered nurse whilst on duty.

The nurse manager plans and coordinates training both internal and external. Training plans are developed for in-service with sessions held throughout the year. Registered nurses interviewed stated that they can access to external trainings and professional development program. 81% of staff have a national qualification in care of elderly. Staff also attended training day with several sessions around dementia care such as communication, behaviours that challenge, and nutrition and dementia.

This training day is provided by Midland regional dementia behavioural support advisory coordinator.

An annual training plan is implemented but this does not include continence management training and individual staff training records are not maintained.

There are implemented competencies for staff related to medication administration.

The registered nurses and GP's have current practicing certificates.

Seven of the seven staff files sampled have current performance reviews.

E4.5d- the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies. Three staff files reviewed had completed orientation records.

E4.5f Caregivers who work in the dementia unit, have completed the required dementia standards, and two staff members are awaiting their results from Health ED Trust.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The annual training plan is implemented and covers a range of subjects.

**Finding:**

Staff did not receive a training around continence management in the last two years. Individual training records are not monitored ensuring that all staff receive minimum eight hours training a year.

**Corrective Action:**

Ensure that staff receive training around continence management and staff training records are maintained.

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

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

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

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

**Attainment and Risk:** FA**Evidence:**

There is a staffing policy, which provides the documented rationale for staffing, and skill mixes. There are a total of 52 staff. There are two clinical coordinators, 10 RNs, 26 caregivers, one enrolled nurse, two maintenance staff, one cook and four cook assistants, one DT, one activity coordinator, four housekeeping staff, one administrator, one cultural and one spiritual advisor. A review of the roster and interviews with staff and five residents did not indicate any issues around staffing levels. All caregivers are supervised by registered nurses on shift at all times. The nurse manager stated that staff who are coming to duty start 15 minutes earlier than what the roster indicates. Staff interview confirmed this.

The following staff are rostered:

Rest Home – Eight residents

AM – 1 caregiver (7am -3pm) PM – 1 caregiver – (3pm-11pm) Nocte- 1 caregiver – (11pm- 7 am).

Hospital – (five rest home and 17 Hospital)

AM: 2 caregiver (7am-3pm); 1 caregiver (7am-1pm)

PM: 1 caregiver (3pm-11pm); 2 caregivers (3pm-8pm),

Nocte: 2 caregiver 11-7 pm

There is a registered nurse on duty at all times in the hospital.

Dementia Unit – 13 residents

AM – 2 caregivers (7am -3pm) PM – 2 caregivers (3pm-11pm) Nocte- 1 caregiver – (11pm- 7 am).

There are two clinical coordinators. The two clinical coordinators work a combined 40 hours a week, weekdays cover. The nurse manager works full time, Monday to Friday over both facilities. Nurse manager is on call with the clinical coordinators.

**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.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service retains relevant and appropriate information to identify residents and track records. Paper based files are in place for each resident. A review of five resident's files confirmed that all information is current. Interviews with staff confirmed knowledge of the recording requirements. All residents' files are maintained in a secure area in the nurses' office in all three areas and no personal information is displayed in the public arena. All records presented are legible and name and designated of service provider identifiable. All files reviewed record fully integrated continuity of notes. Discussions with staff confirmed what notes and files were constantly updated to ensure continuity of care.</p> <p>D7.1 Entries are legible, dates and signed by the relevant caregiver or registered nurse including designation.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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.

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Prior to entry to Maryann potential residents, have a needs assessment, completed by the needs assessment and co-ordination service (NASC) to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for resident's families/whanau at entry. The information pack includes relevant aspects of service and residents and/or family/whanau are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. There is an admission procedure in place and admission documentation, which includes resident and next of kin details. The registered nurse on duty completes all the admission documentation and relevant notifications of entry to the service. The registered nurses interviewed were able to describe the entry and admission process. The GP is notified of the new admission. Signed admission agreements sighted.</p> <p>D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D14.1: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E3.1: Two resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care.</p> <p>E4.1b: There is written information on the service philosophy and practices particular to the unit included in the information pack including (but not limited to) a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with</p>

emphasis on  
1. Minimising restraint.  
2; Behaviour management.  
3; Complaint policy.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The admission policy describes the declined entry to services process. Maryann records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>D16.2. 3. 4: The seven resident files (one rest home, four hospital, two dementia) reviewed identified that an initial nursing assessment and care plan was completed within 24 hours and seven of seven files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by registered nurses and amended when current health changes. Five of seven care plans (three hospital, two dementia) evidenced evaluations completed at least six monthly. The other two residents files; included – one resident that had not yet been in the service for six months and one was for respite care. Activity assessments and the activities care plans have been completed. These are updated six monthly. Four of four residents (two rest home and two hospital) interviewed stated that they and/or their family/whanau were involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed in all resident files sampled.</p> <p>D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days on admission. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly.</p> <p>A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) coombes falls risk assessment, b) waterlow pressure area risk assessment, c) continence assessment, d) skin assessment and pain assessment. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Seven files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents' health status. They will often email him asking his advice and he always gets back to them as quickly as possible. If it urgent they will ring. He states they are a good team and he enjoys working with them.</p> <p>Tracer Methodology rest home:</p>

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

Tracer methodology hospital:

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

Tracer methodology dementia:

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The initial nursing InterRAI assessment and care plan is completed within 24 hours of admission and the long term care plan is completed within three weeks. Admission documentation obtained includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. There is a disturbing behaviour assessment and monitoring form. The behaviour chart describes the incident, behaviour and consequences. They are evaluated monthly by a registered nurse. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment and the first resident care plan within the required timeframes. All resident files sampled evidenced an initial assessment and care plan with reference to the information gathered on admission.</p> <p>Assessments are conducted in an appropriate and private manner. Relatives and residents advised on interview that assessments were completed in the privacy of their room. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Family/whanau members (eight) and four residents interviewed are very satisfied with the support provided.</p> <p>ARC E4.2: Two resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.</p> <p>E4.2a Challenging behaviours assessments are completed.</p>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term care plan from information gathered over the first three weeks of admission. There is evidence a holistic approach to care planning with resident and family/whanau input ensuring a resident focussed approach to the whole process. There is evidence of six monthly review and evaluation, which is signed by a registered nurse.</p> <p>This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist.</p> <p>The integrated resident file also contains admission documents, informed consent forms, care documents, risk assessment tools and reviews, medical documentation, test results (laboratory and radiology), allied health notes, referrals and other relevant health information, associated assessments such as activities, behavioural, recordings (weight, blood pressure), incidents and accidents and any correspondence. Acute care plans were in place with interventions, management and evaluations. All were signed off when resolved.</p> <p>All seven resident files (one rest home, four hospital, two dementia) reviewed identified that family were involved. Eight out of eight family/whanau advised on interview that they were involved in the development of the care plan and were kept well informed of changes to care or health status and support by staff is consistent with their expectations.</p> <p>Notes by the GP and allied health professionals are evidenced. Family/whanau (four hospital, two rest home, two Dementia) interviewed are positive and complimentary about the staff, clinical and medical care provided. All were satisfied with the activities programme.</p> <p>D16.3f: Seven resident files reviewed identified that family/whanau were involved.</p> <p>D16.3k: Acute care plans are in use for changes in health status.</p>

**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.

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Seven resident files were reviewed (four hospital, two dementia, one rest home). The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, and registered nurses. A review of acute term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews for rest home, hospital residents and dementia residents and more often if required. The registered nurse/clinical coordinator are responsible for the education programme and ensure all staff has the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers on each shift in the rest home and dementia unit and by the registered nurse in the hospital (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral.

The five caregivers (two dementia, three hospital/rest home) interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, pressure mattresses, hoists, wheelchairs, weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. Residents' weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated. All falls are reported on the resident accident/incident form.

Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. A diabetes in-service was held July 2013. One resident with type two diabetes and is on insulin did not have instructions for management of diabetes or blood sugar monitoring reflected in their long term care plan. This is an area requiring improvement. Four of four residents (two rest home and two hospital) and eight relatives/whanau (four hospital, two rest home and two dementia) interviewed were complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available and stored in a locked cupboard in each wing. Wound assessment and wound management plans are in place for one resident with a wound - a skin tear. An acute care plan is in place and reviewed monthly.

The clinical coordinator and two registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management training has not been provided to staff (link 1.2.7.4). Pressure area in-service has been provided (June 2013). During the tour of facility, it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained and stated that staff were respectful.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is evidence of three monthly medical reviews for rest home, hospital residents and dementia residents and more often if required. The registered nurse/clinical

coordinator are responsible for the education programme and ensure staff has the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers on each shift in the rest home and dementia unit and by the registered nurse in the hospital. Staff reports they have the necessary equipment required to provide care. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. All falls are reported on the resident accident/incident form. Coombes fall risk assessments are completed on admission and reviewed at least six monthly or earlier if required. Wound assessment and wound management plans are in place for one resident with a wound - a skin tear. Acute care plan is in place and reviewed monthly.

**Finding:**

One resident with type two diabetes and is on insulin did not have instructions for management of diabetes or blood sugar monitoring reflected in their long term care plan.

**Corrective Action:**

Ensure that all residents with diabetes have instructions for the management and monitoring of diabetes identified in the LTCP

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is Diversional Therapist and two activities coordinators at Maryann who are responsible for the delivery of the activities programme. The diversional therapist works across Maryann and Marire sites 70 hours a fortnight and is responsible for oversight of the recreational programme and the rosters. One activities coordinator works 55 hours a fortnight in the rest home/hospital and one activities coordinator 30 hours a fortnight in the dementia unit. Both activity coordinators are currently undertaking diversional therapy training. Activities are planned weekly and a programme is produced for each area. The diversional therapist and activities coordinators report that the programme is adjusted to meet the needs and interests of the residents if required. Activities are provided in the lounge, dining area, garden (when weather permits) and one on one input in resident's rooms when required. On the day of audit, residents were observed being actively involved with a variety of activities. Interviews with four residents (two rest home and two hospital) and eight relatives/whanau (four hospital, two rest home, and two dementia), five caregivers (two dementia, three rest home/hospital) and three registered nurses confirm that activities happen on a daily basis. The programme includes residents being involved within the community with churches and schools. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. This is used to develop the activities plan and this is reviewed six monthly as part of the care plan review/evaluation. The diversional therapist works with the two activities coordinators to complete the activities plans and the activity plan reviews. The resident/family/whanau/EPOA as appropriate is involved in the development of the activity plan. A record is kept of individual resident's activities and monthly progress notes completed. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Maryann has its own van for transportation. Residents interviewed described attending concerts, going shopping, lunches and picnics and visiting other aged care facilities to take part in competitions and quizzes.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

### 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is at least a three monthly review by the medical practitioner. D16.4a: There is documented evidence that the care plans were reviewed by registered nurses and amended when current health changes. Care plans are reviewed and evaluated by the registered six monthly or when changes to care occur as sighted in five of seven care plans sampled (three hospital, two dementia). The other residents' one has not yet been in the service for six months and one was for respite care. There are acute care plans to focus on acute and short-term issues. Two acute (short term) care plans reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. Care staff is informed of any changes to resident need at handover between shifts. Examples of acute care plans in use included; falls, infections and wounds. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift. ARC D16.3c: All initial nursing assessment/care plans were evaluated by a registered nurse within three weeks of admission.</p>

**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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, speech language therapist and mental health services for the older person.

D16.4c: The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.

D 20.1; Discussions with the registered nurses and clinical coordinators identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, occupational therapist and physiotherapist.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept

and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A discharge summary, transfer form, a copy of the resident medication chart and their resuscitation status accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. Family/whanau contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.

**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.

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

**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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>Medication policy covers all aspects of medicine management including prescribing, dispensing, administration, review, storage and disposal that align with accepted guidelines. There are three medication rooms (rest home, hospital, and dementia). The service uses four weekly blister packed medication management system. A medication checklist is completed on arrival of the medication from the pharmacy and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are given by RNs in the hospital and senior care givers in the rest home and dementia unit who have completed a medication competency; there is a list of 'competent staff' in the front of the medication folders. Medications are stored in a locked trolley in each of the medication rooms. There is a medication fridge and the temperature for each fridge is checked daily. Controlled drugs are stored in a locked storage cupboard in the hospital medication room. Two medication competent persons (one a registered nurse) sign for controlled drugs. Controlled drugs are audited weekly which includes a stock take, this was evidenced in the controlled drug register. Medication charts have photo ID's. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. The service has an incident/accident form for the reporting of all adverse reactions and errors. Medication errors are reporting through the incident and accident reporting programme and corrective action plans initiated which are followed up. There is a signed agreement with the pharmacy. There is a medication return box and this is cleared by the</p>

pharmacy and signed out

Staff signs for the administration of medications on medication signing sheet. Signing sheets correspond to instructions on the medication chart. Fourteen out of 14 medication charts sampled show that all medications have been signed when administered according to the medication chart. Medication competency tests are completed annually and also if there is a medication administration error. Annual medication training is provided by Douglas Medico. Last held May 2013. The clinical coordinators often randomly do spot medication audits. The medication policy includes self-medication. There is currently one resident self-administering medications and this resident has a current medication competency assessment documented. There is emergency oxygen available. The regulators have been checked.

Residents/relatives interviewed stated they are kept informed of any changes to medications.

All eye drops sighted have been dated on the day they were opened.

D16.5.e.i.2: Medication profiles are legible, up to date. There were no three monthly reviews by the G.P for five of 14 charts sampled. Three of 14 charts sampled did not have the frequency of 'as required' drugs documented. These areas require improvement.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medication reconciliation is completed by the registered nurses for new admissions and for all medications delivered by the pharmacy. All medication charts contain photographic ID and all medications prescribed are signed by the GP. Medication charts document if there are any known allergies. Controlled drugs are kept in the hospital unit CD cupboard. There is a weekly physical check.

**Finding:**

i) Five out of 14 medication charts do not have a signed off three monthly review by the GP. ii) Three of 14 charts sampled did not have the frequency of 'as required' drugs documented.

**Corrective Action:**

i) Ensure medication review occur three monthly. Ensure the three monthly reviews have been signed off. (ii) Ensure the 'as required' meds have a frequency charted by the GP.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>A domestic services manager has been appointed who oversees the service. Maryann employs two cooks and all food is cooked on site. There is a four weekly rotating winter and summer menu that was approved by a dietitian. This is reviewed two yearly. A special diets in-service was held in July 2013 by the dietitian. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted and are within safe limits. Food temperatures are recorded daily. All food in the pantry is rotated and stored off the floor. Opened food in the fridges and freezer is dated.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted in a folder in the kitchen, which is able to be viewed only by kitchen staff. Special diets being catered for include diabetic diet and pureed diet. Weights are recorded weekly/monthly as directed by the registered nurses and if there are any dietary changes these are reported by the registered nurse to the cook. A new nutritional profile is completed. Residents report satisfaction with food choices, meals are well presented. Lunchtime meal was observed being served and was attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required. The cook was able to identify those residents on special diets. One cook has completed 167 and 168. The other cook employed in October 2013 is booked to complete 167. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. Chemical training was held April 2013.</p> <p>E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours in the dementia unit.</p> <p>D19.2 Staff have been trained in safe food handling.</p>

#### 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.

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

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

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

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

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

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

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

**Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals bottles sighted are labelled with the manufacturers labels. There is appropriate protective equipment and clothing for staff including gloves, shoe covers, gumboots, shoe covers and plastic aprons. There is a chemical spills kit handy. A hazard register identifies hazardous substance and staff interviewed indicated a clear understanding of processes and protocols. Chemical training was held April2013. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards. SDS sheets are available.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Maryann is a one level facility providing rest home, hospital and dementia care. The 24 bed hospital facility and 16 bed dementia unit were purpose built. The eight bed rest home has been refurbished. The existing building holds a current warrant of fitness, which expires 3 May 2014. Electrical equipment is checked at least every two years and was last completed February 2014. The facility van has a current warrant of fitness and registration. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets/bedrooms and kitchen areas. Reactive and preventative maintenance occurs. There is a maintenance schedule in place. Fire equipment is checked by an external provider. Resident rooms have carpet or vinyl. In the dementia unit, all floors in the bedrooms are vinyl and living areas carpeted. The corridors in the hospital and rest home are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and the garden area is attractive. The garden in the dementia unit is secure and includes a built up gardens, aviary, chicken coop, swing seat and a covered area containing a fiddle board. The garden/decking area has furniture and umbrellas that provide shade. There is wheelchair access to all areas. The hospital and rest home have all appropriate equipment including hoists, a bath trolley, hi low beds and pressure relieving mattresses. There is adequate storage space for hoists, wheelchairs, products and other equipment. The service has an efficient Austco bell system.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids, shower chairs, chair scales. All caregivers (5) and registered nurses (3) interviewed state there is adequate equipment to deliver safe and timely care for the residents.

E3.3e: There are quiet, low stimulus areas that provide privacy when required. There is a quiet room in the dementia unit.

E3.4.c: There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

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

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

ARC E3.3d ARHSS D15.3c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The hospital has two resident rooms with en-suites and the dementia unit has three resident rooms with en-suites. All other rooms are single with hand basins. The bathrooms and toilets have appropriate flooring and handrails. There are communal toilets and showers close to bedrooms. The three communal bathrooms in the hospital wing are also suitable for a trolley bath to be used. Toilets are located close to dining rooms and lounges for residents' use. A visitor's toilet is available. All are appropriately signed. Toilet doors in the dementia unit are all painted the same colour. Privacy locks are in place. The dementia unit and hospital wings are newly built and the rest home has been fully refurbished.

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Bedrooms in all the units are of adequate size appropriate to the level of care provided. The hospital level rooms allow for the easy manoeuvre of hoists, lazy boy chairs and other equipment required to safely deliver care. The doorways are wide and open out to allow for the easy access of equipment and ambulance trolleys into the room. All hospital residents have high low beds. Observation on day of audit demonstrated walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with caregivers (five). Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists. The rooms are uncluttered and contain resident's personal items. Residents were encouraged to personalise their bedrooms. Residents interviewed (two hospital, two rest home) confirm their bedrooms are spacious and they can personalise them as desired. Family/whanau interviewed (four hospital, two rest home, two dementia) state they are very happy with the bedrooms.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are several large lounges and dining areas. The lounges in the hospital and dementia unit are open plan with kitchenettes central to the areas. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility as sighted on the day of audit. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are cleaning and laundry policies and processes. The domestic services manager coordinates the service. Maryann has a small laundry for small items as all

laundry is sent to Marire rest home. Adequate linen supplies were sighted. Chemicals are stored in a locked room in the laundry. On a tour of the facility, the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning is a seven day a week service. Cleaning rooms are secured and the cleaners trolleys are attended at all time or locked away in the cleaning rooms. All chemicals are labelled with a manufacturer's label. Chemicals are stored in a locked room. An external chemical supplier provides the chemicals, product wall charts, conducts quality control checks and provides training. Chemical training last April 2013. Protective clothing is available including gloves, disposable aprons and face shield. Residents and relatives expressed satisfaction with cleaning and laundry services.

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a comprehensive plan for emergency situations, which covers a wide range of possible situations such as earthquakes, fire, essential service outage, unauthorised access, IT failure and pandemic situations. Civil defence kit is kept in the basement and regular stocktake occur. Key staff hold first aid certificates including kitchen staff, RNs, staff who work at night duty and caregivers at the rest home. There is an approved evacuation plan dated 14th December 2012 and staff training in fire training occurred 17 December 2013. The service has emergency lighting and BBQ's. A store of emergency water is kept as part of their civil defence kit. Extra blankets are also available. A call bell system is available in all areas and indicator panels in each area. There are emergency bells available in the dementia units and staff wears emergency pendant to seek assistance. Residents spoken to in the rest home stated their bells are answered promptly. The building is secured during the hours of darkness and all visitors and contractors to the facility need to 'sign in' for identification.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The facility is heated by Brevis heating system, which is ducted into the hallways, lounges and bedrooms of the hospital and dementia wing. In the rest home, the Brevis heating system is ducted into the bedrooms. The temperature can be adjusted to suit individual resident temperature preference. Rooms are well ventilated and windows provide natural light. Facility temperatures are monitored. Four residents and eight family/whanau interviewed stated the temperature of the facility was comfortable.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

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

---

### **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. E.g. lap belt in a wheelchair to maintain positioning for self-propulsion. Interview with the restraint coordinator confirmed restraint is only used in hospital wing and there are eight residents using bedsides as restraint. There are two residents using a lap belt as an enabler and they signed consent form for use of this. All required documentation for restraint and enabler use is recorded in the restraint folder.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Restraint policy define the restraint approval process. Considerations are made for restraint to be the least restrictive intervention available. Restraint coordinator job description clearly defines the role including quality assessment, education, care planning, use of equipment, restraint approval group, consultation and communication. The approval process is undertaken, where relevant, with the resident and family, other health professionals, specialists. All restraints are approved by the GP and the restraint coordinator. Restraint consent form is signed by all parties, this was evidenced in the restraint consent forms reviewed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by the registered nurses, restraint coordinator and GP in partnership with the resident and their family/whanau. Assessment for use of a restraint form is completed as part of the assessment process prior to initiating restraint and includes criteria from (a) to (h). All restraint alternatives require to be

considered and/ or used before restraint is considered. Risks associated with restraint use are identified and documented and communicated to all concerned. Restraint assessments for residents requiring restraint were documented for all those who requiring them, sighted on the day of audit.

**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.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Restraint use is monitored as per policy and procedure. Risks are identified with each episode of restraint use. Audits of restraint monitoring are conducted. Approval process is followed as per policy and individual episodes of restraint are implemented only as a last resort. Resident files reviewed showed that alternative interventions were considered and attempted prior to restraint approved. Each of restraint use is documented in sufficient detail to show indication of use, duration and its outcome. A restraint register is maintained by the restraint coordinator and appropriate information is recorded.

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

Evaluations have occurred three monthly for the residents on the restraint register.

Restraint is evaluated in collaboration with the residents and family. Evaluations are documented on residents' care plans.

Assessment for trail of removal of restraint forms are completed as part of the evaluation of restraint minimisation. One restraint was removed on 12 March 2014 following an evaluation of restraint monitoring records, which was showing high level of restlessness during use of restraint. The resident was monitored for three weeks ensuring that the resident's safety is maintained without restraint.

**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.

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

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service continues to monitor use of restraint at least three monthly in the restraint approval group meeting, and as part of six monthly review with family/whanau involvement. Restraint is monitored through the risk management meetings. Restraint Minimization audit is last completed on February 2014.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(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

**Attainment and Risk:** FA

**Evidence:**

The service has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There is an infection control policy and procedure manual which is readily accessible to all staff. One of the clinical coordinators undertakes the role of Infection control and prevention and she is also responsible of collection of surveillance data. Infection control is a standing agenda item at the three monthly risk management meeting where all issues and infections are discussed with staff. All results and infection control matters are reported to the clinical coordinator on a monthly basis or sooner if there is an issue. The infection control co-ordinator collates a monthly record of infections data and then a copy of these results are retained at the staff reading folder for staff to read and sign off. The infection control co-ordinator and the resident's general practitioner are notified promptly of any positive pathology that is identified as an infection.

Discussion with staff confirmed that infection control coordinator and registered nurses are always available for emergent issues. Infection control program is reviewed annually and most recently, the service purchased Bug Control infection prevention and control manual. Staff are well informed about infection control practices and reporting. Memo's related to infection control issues are noted in the staff reading folder. The infection control coordinator's job description describes the key responsibilities and performance indicators of the Infection control activities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Infection control coordinator maintains her practice by attending infection control updates by Bug Control NZ. The infection control coordinator stated that she has good external support from the infection control advisors from the local DHB.  
All staff complete an infection control competency at orientation. Infection control education occurs at the caregivers forum, through hand washing audits and is included as part of the in-service training programme. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. Infection control policies and procedures are used to minimise the risk of exposing residents and staff to others with infection risk. Staff are advised about prevention of transmission of disease and, if sick, to remain at home. Visitors are informed of any outbreak issues and advised not to visit if unwell.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. The infection control policies and procedures are reviewed in 2013 and these are current and comply with standards legislation and guidelines for infection control practises. The service also purchased Bug Control Infection Prevention and Control Manual 2014. All staff are involved in the implementation of policies.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control co-ordinator is responsible for co-ordinating education and training to staff. Orientation package includes specific training around hand washing and standard precautions. Training on infection control is an agenda item at caregiver, food service and housekeeping meetings. Staff have an individual hand washing audit annually. Food services and housekeeping staff receive infection control education relevant to their areas. Infection control is included in the annual in-service training

programme. Infection control education is last provided on February 2014. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

**Attainment and Risk:** FA

**Evidence:**

The type of surveillance undertaken is appropriate to the size and complexity of the service. Mc Geer (2012) definition is used for the identification and classification of infection events, indicators or outcomes. Surveillance data is collected for rest home, hospital and the dementia unit. Results of surveillance are acted upon, evaluated, and reported to relevant staff in a timely manner. Classification of infection events are included on the infection report form. All infections are entered on to an infection register. This data is monitored and evaluated. Outcomes and actions are discussed at the three monthly risk management meetings, and caregiver's forum. Each resident has an individual infection report that includes reporting on skin, eye, urinary, respiratory, and gastrointestinal and other infections that may be identified.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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