# Agape Care Limited

## Current Status: 8 April 2014

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

## General overview

Milton Court Rest Home is certified to provide rest home care for up to 26 residents and dementia level care for up to 10 residents. The service is owned by a registered nurse. A full time registered nurse manager is responsible for the daily operations of the service. There are 20 staff employed by the service.

There are improvements required relating to advance directives, open disclosure, investigating accidents, responsibility for clinical documentation, interventions and short term needs, behaviour management documentation, pain and continence assessments, aspects of medication management, the location of the designated resident smoking area and the call system.

## Audit Summary as at 8 April 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 8 April 2014

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

### Organisational Management as at 8 April 2014

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

### Continuum of Service Delivery as at 8 April 2014

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

### Safe and Appropriate Environment as at 8 April 2014

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

### Restraint Minimisation and Safe Practice as at 8 April 2014

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

### Infection Prevention and Control as at 8 April 2014

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

## Audit Results as at 8 April 2014

### Consumer Rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents.

Informed consent processes are implemented by the service. Staff demonstrate an awareness of ensuring residents are informed and have choices relating to the care that they receive. An identified improvement is around ensuring advance directives are signed only by competent residents.

A policy on open disclosure is in place, there is an identified improvement around ensuring there is evidence of informing residents and families following an adverse event.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

### Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. A nurse manager is responsible for the day-to-day operations. The owner who is also a registered nurse supports her onsite on average three days a week.

Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified.

A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. There is a required improvement around the timely investigation of accidents by a registered nurse.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. Education and training programmes meet contractual requirements with one exception. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type and demonstrate service integration.

### Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack on rest home and dementia care services is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The GP completes three monthly reviews. There is an improvement required around responsibility for clinical documentation, interventions and short term needs, behaviour management documentation, pain and continence assessments.

There are separate activity programmes for the rest home and dementia wing that are resident focused and provide a variety of activities including entertainment and outings to meet the interests and abilities of the consumer group. Community links are maintained.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around aspects of medicine management.

All meals and baking is prepared and cooked on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There are nutritious snacks available over 24 hours.

### Safe and Appropriate Environment

Milton Court is a rest home and dementia care facility. The building has a current building warrant of fitness and approved fire evacuation plan. There is a planned maintenance schedule in place for the interior and exterior building, grounds and gardens. All rooms have a hand basin. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. The communal dining and lounge areas encourage social interaction within the rest home and the dementia unit.

Outdoor areas are safe and accessible for the rest home residents. The dementia unit has safe external gardens and grounds.

Improvements are required regarding the location of the designated resident smoking area and the call system.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

There is adequate equipment for the safe delivery of care. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment.

### Restraint Minimisation and Safe Practice

Environmental restraint is in place. Residents at the rest home level were observed freely coming and going through the key pad access-only gate. Interviews with three rest home level residents confirm they come and go as they please.

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. Any restraint/enabler use is recorded in an auditable format. Staff are required to attend restraint minimisation and safe practice education.

There were no residents using a restraint or an enabler during this audit.

### Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and in the annual training plan. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification infections. Results of surveillance are acted upon, evaluated and reported at management and staff meetings.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Agape Care Limited |
| **Certificate name:** | Agape Care Limited |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Milton Court Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 8 April 2014 | **End date:** | 9 April 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 31 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 7 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 17 | Total audit hours | 41 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 20 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 27 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Milton Court Rest Home is certified to provide rest home care for up to 26 residents and dementia level care for up to 10 residents. There were 31 residents living at the facility on the day of audit, including 21 residents at a rest home level of care and 10 residents living in the secure dementia unit. The service is owned by a registered nurse. A full time registered nurse manager is responsible for the daily operations of the service. There are 20 staff employed by the service. There are improvements required relating to advance directives, open disclosure, investigating accidents, responsibility for clinical documentation, interventions and short term needs, behaviour management documentation, pain and continence assessments, aspects of medication management, the location of the designated resident smoking area and the call system. |

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| **Outcome 1.1: Consumer Rights** |
| Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families.  Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents.  Informed consent processes are implemented by the service. Staff demonstrate an awareness of ensuring residents are informed and have choices relating to the care that they receive. An identified improvement is around ensuring advance directives are signed only by competent residents. A policy on open disclosure is in place, there is an identified improvement around ensuring there is evidence of informing residents and families following an adverse event.  The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place. |

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| **Outcome 1.2: Organisational Management** |
| Services are planned, coordinated, and are appropriate to the needs of the residents. A nurse manager is responsible for the day-to-day operations. The owner who is also a registered nurse supports her onsite on average three days a week. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.  Adverse, unplanned and untoward events are documented by staff. There is a required improvement around the timely investigation of accidents by a registered nurse.  Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. Education and training programmes meet contractual requirements with one exception. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type and demonstrate service integration. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a policy for admission and entry for the rest home. A service information pack on rest home and dementia care services is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement are discussed with them. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The GP completes three monthly reviews. There is an improvement required around responsibility for clinical documentation, interventions and short term needs, behaviour management documentation, pain and continence assessments.  There are separate activity programmes for the rest home and dementia wing that are resident focused and provide a variety of activities including entertainment and outings to meet the interests and abilities of the consumer group. Community links are maintained.  Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around aspects of medicine management.  All meals and baking is prepared and cooked on site. Resident’s individual food preferences, dislikes and dietary requirements are met. There are nutritious snacks available over 24 hours. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Milton Court is a rest home and dementia care facility. The building has a current building warrant of fitness and approved fire evacuation plan. There is a planned maintenance schedule in place for the interior and exterior building, grounds and gardens. All rooms have a hand basin. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. The communal dining and lounge areas encourage social interaction within the rest home and the dementia unit.  Outdoor areas are safe and accessible for the rest home residents. The dementia unit has safe external gardens and grounds.  Improvements are required regarding the location of the designated resident smoking area and the call system.  All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures. There is adequate equipment for the safe delivery of care. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Environmental restraint is in place. Residents at the rest home level were observed freely coming and going through the key pad access-only gate. Interviews with three rest home level residents confirm they come and go as they please.  The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. Any restraint/enabler use is recorded in an auditable format. Staff are required to attend restraint minimisation and safe practice education.  There were no residents using a restraint or an enabler during this audit. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and in the annual training plan. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification infections. Results of surveillance are acted upon, evaluated and reported at management and staff meetings. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 35 | 0 | 6 | 4 | 0 | 0 |
| **Criteria** | 0 | 83 | 0 | 5 | 5 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Although interviews with six of six families report that the service notifies them following an adverse event, this is not being consistently documented in the residents’ files. | Ensure there is documented evidence of residents and families being kept informed following an adverse event. | 90 |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | Where the GP has deemed the resident incompetent to make a decision the resuscitation authorisation form has been inappropriately signed. | Ensure resuscitation authorisation forms are correctly signed. | 90 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Out of the twenty incident/accident reports that were selected for review, there were fifteen injuries that occurred. Although the nurse manager signs off on each accident and incident form, there was also a lack of evidence to reflect a timely investigation of the injury by the nurse manager in seven of the fifteen completed accident/incident forms where an injury had been sustained. | Ensure there is evidence of the timely response by a registered nurse following an adverse event where an injury is sustained. | 60 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.1 | 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. | PA Moderate | The clinical supervisor (senior caregiver) has completed admission assessments (five), initial care plans (five), long term care plans (six) and evaluations (four) of the six resident files sampled. | Ensure a registered nurse completes each stage (assessment, planning, provision, evaluation, review, and exit) of provision of care. | 30 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | There are no pain assessments in place for two residents (one rest home and one dementia) who identify with pain on admission. There are no disturbing behaviour assessments on admission for three dementia care residents (link E.4.2). | Ensure assessment tools are completed for residents who identify with pain. Ensure behaviour assessments are completed on admission for all dementia care residents. | 30 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | E4.3 Three of three dementia resident care plans reviewed, did not identify current abilities, level of independence, identified needs and alternative strategies (over a 24 hour period) based on assessment and prevention of the individuals specific behaviours. ii) One dementia resident hospitalised following seizures does not have a nursing management plan in place for seizures. iii) There is no management plan for rest home resident with angina, iv) There are no short term care plans in place for a) resident with chest infection and b) resident with shortness of breath and acute congestive heart failure. | Ensure care plans for dementia residents identify specific needs and alternative strategies over a 24 hour period for the management and prevention of behaviours. ii) and iii) Ensure care plans reflect the resident needs, and iv) Ensure short term needs are documented. | 30 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i)Wound assessments are incomplete and there is no evidence of wound monitoring. (ii) There is no continence assessment or continence management plan in place for a dementia care resident with recent reports of incontinence. (iii) There is no pain assessment or documented interventions for a) dementia resident with a new episode of knee pain and b) one rest home resident with an exacerbation of chronic pain. (iv) There is no RN intervention or follow up for a resident (previously under mental health services) with altered mood as written and highlighted in the progress notes. | (i) Ensure wound care documentation is completed as per policy. (ii) Ensure continence assessments and management plans are in place where applicable (iii) Ensure pain assessments are completed for new episodes of pain and breakthrough pain to identify strategies to manage. (iv) Ensure there is RN review of progress notes to ensure appropriate interventions are implemented for significant events. | 60 |
| 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 Low |  |  |  |
| 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 Low | (i)Four out of 12 medication charts require an indication for use of prn medications charted. (ii) There is no evidence of weekly controlled drug physical stocktakes undertaken by a RN and one other medication competent person. | (i)Ensure prn medication prescribed have an indication for use. ii) Ensure weekly controlled drug physical stocktake is completed. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.4 | The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The designated resident smoking area is not located far enough away from the building to prevent other residents from being affected by smoke fumes | Ensure the designated resident smoking area does not adversely affect other residents. | 30 |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Moderate | An appropriate call system for this rest home and secure dementia unit is not in place. | Ensure residents have access to an effective call system to summon assistance when needed. | 60 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive training on the Code of Health and Disability Services Consumers’ Rights (the Code) during their induction to the service and through the two-yearly education programme. Interviews with four caregivers (one senior caregiver/clinical supervisor, one caregiver who works only in the rest home and two caregivers who work in the dementia unit and in the rest home), one activities coordinator, one cook, and one health and safety officer confirm their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Details relating to the Code are included in the Resident Welcome Pack that is provided to new residents and their family. The nurse manager discusses aspects of the Code with residents and their family on admission. An explanation of the Code, including the complaint’s process is also contained in the resident admission agreement. Discussions relating to the Code are held informally during the quarterly residents' and family meetings, evidenced in an interview with the nurse manager. Three rest home residents and six relatives interviewed report their rights are being upheld by the service. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service ensures that the residents’ right to privacy and dignity is recognised and respected at all times. Privacy, dignity and rights are a regular agenda item in the residents’ meetings (meeting minutes sighted). The residents’ personal belongings are used to decorate their rooms. All rooms are single rooms. Discussions of a private nature are held in the resident’s room. Four caregivers interviewed (one senior caregiver/clinical supervisor, one caregiver who works in only in the rest home and two caregivers who work in the dementia unit and in the rest home) report they knock on bedroom doors prior to entering rooms, ensure doors and curtains are shut when cares are being given and do not hold personal discussions in public areas. Three rest home residents and six relatives interviewed confirm the residents’ privacy is respected.  Four caregivers interviewed report that they encourage the residents' independence by encouraging them to be as active as possible.  Guidelines on abuse and neglect are documented in policy. There is an expectation that staff will work within the organisation’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code of Health and Disability Commissioner Consumers’ Rights.  There have been no reported instances of abuse or neglect at the facility. Staff receive mandatory education and training on abuse and neglect. Four of four caregivers interviewed are aware of the signs of abuse and neglect. Two of the four caregivers work all three shifts (morning, afternoon and night). |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is committed to ensure that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. Cultural values and beliefs are documented in the resident’s care plan. A specific Maori health care plan is available for Maori residents. There are presently no Maori residents living at the facility. Maori consultation is available through the Waitemata District Health Board. The service also has links with local kaumatua when assistance is required. Staff receive education on cultural awareness during their induction and as an in-service topic. The most recent Maori cultural education in-service took place in 2010. This in-service was provided by the activity coordinator’s son who identifies as Maori. Plans are in place for a Maori cultural training day in 2014. The four caregivers interviewed report specific cultural needs are identified in the residents’ care plans. They are aware of the importance of whanau in the delivery of care for their Maori residents. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. Beliefs and values are discussed and incorporated into the care plan. Long-term care plans are completed within three weeks of admission. Family are encouraged to be involved in this process. Following the initial care-planning meeting, care plans are reviewed every three months.  Three rest home residents and six of six family members interviewed confirm they are involved in developing a plan of care for their family member, which includes the identification of 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.

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All staff have a position description to describe their working boundaries in caring for the residents. A staff code of conduct, house rules and conflict of interest are clearly defined in the policies and procedures and are discussed during the induction process. Professional boundaries are also included in the staff performance appraisal process. The clinical supervisor (senior caregiver) has been delegated the role of completing initial assessments and long term care plans for the residents with sign-off by the registered nurse (link 1.3.3.1). Interviews with four of four caregivers confirm their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through monthly education and training sessions, discussions at handover, six-weekly staff meetings, and performance management if there is infringement with the person concerned. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Evidence-based practice is evident, promoting and encouraging good practice. The general practitioner visits weekly. The geriatric nurse specialist from Waitemata District Health Board (WDHB) provides monthly education to staff. A nurse specialist from WDHB is available for consultation on wounds and a WDHB dementia nurse specialist is also available as needed. A podiatrist visits the facility every six weeks to three months, external entertainers visit the facility, pet therapy takes place, and regular van outings are available to the residents. There is a monthly in-service education and training programme for staff. The nurse manager reports the dementia unit is based on a philosophy of linking into the resident’s senses to evoke memories. Examples include walking around the block, and picking flowers. The nurse manager has also developed the ‘ebb and flow of life’, which are activities that are related to the seasons to evoke memories around the times of the year. Three residents (rest home) and six of six families interviewed expressed their satisfaction with the care delivered. The GP is also satisfied with the level of care that is being provided. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A policy on open disclosure is in place. The nurse manager reports discussions are held with residents and relatives regarding any changes in care provision. Fifteen accident and incident forms where an injury was sustained were randomly selected for review. Although interviews with six of six families report that the service notifies them following an adverse event, this is not being consistently documented in the residents’ files. Residents meetings are held three-monthly. Families are invited to attend. The organisation has multilingual staff that can provide interpreter services. If necessary, interpreter services can be accessed through the WDHB. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A policy on open disclosure is in place. The nurse manager reports discussions are held with residents and relatives regarding any changes in care provision. Fifteen accident and incident forms where an injury was sustained were randomly selected for review. There was a lack of documented evidence to reflect families are being kept informed when there is an adverse event. |
| **Finding:** |
| Although interviews with six of six families report that the service notifies them following an adverse event, this is not being consistently documented in the residents’ files. |
| **Corrective Action:** |
| Ensure there is documented evidence of residents and families being kept informed following an adverse event. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Consent is obtained for release of health information, photograph for identification and display, transport, medical or minor procedures.  Four caregivers interviewed are familiar with the code of rights and informed consent when delivering resident cares.  Resuscitation authorisation forms for competent residents are appropriately signed. Where the GP has deemed the resident incompetent to make a decision the resuscitation authorisation form has been inappropriately signed. Competent residents are informed of their choice to withdraw or change their resuscitation status.  D3.1.d Discussion with six family members (four rest home and two dementia) identifies that the service actively involves them in decisions that affect their relative’s lives.  D13.1 There are six of six 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.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Resuscitation authorisation forms for competent residents are appropriately signed. Competent residents are informed of their choice to withdraw or change their resuscitation status. Discussion with six family members(four rest home and two dementia) identifies that the service actively involves them in decisions that affect their relative’s lives |
| **Finding:** |
| Where the GP has deemed the resident incompetent to make a decision the resuscitation authorisation form has been inappropriately signed. |
| **Corrective Action:** |
| Ensure resuscitation authorisation forms are correctly signed. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information on Advocacy Services through the Health and Disability Commissioner’s (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at reception. A poster on Advocacy Services is in a visible location. Interviews with residents and families confirm their understanding of the availability of 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured 24 hours a day, seven days a week by an outdoor gate that requires key pad access. An intercom is placed next to the gate. Rest home level residents and families are free to access this secure area and were observed doing so during the audit. Six of six families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. The service encourages the residents to maintain their relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do so. Residents have access to various community services (e.g., mental health support group, church groups, and activities including van outings and shopping trips). |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisations complaints policy and procedures meets the requirements set forth by the Health and Disability Commissioner’s Office. Timeframes for responding to a complaint are monitored on the complaints register. Complaints forms are available in the Resident Welcome Pack, in the resident admission agreement and at reception. The complaints register documents: the date the complaint was received; the source of the complaint; the date action is to be taken, the date the complaint was actioned, evidence if advocacy was utilised and the date the complaint was closed off. Two complaints were lodged in 2013 and two complaints have been lodged in 2014 (year-to-date). All four complaints, which were relatively minor, were reviewed. Appropriate follow-up actions were taken in a prompt manner and all four complaints have been resolved.  Interviews with three rest home residents and six of six families confirm their understanding of their right to lodge a complaint. Interviews with the owner, nurse manager and four caregivers confirm their understanding of the complaints process. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility is certified to provide rest home and dementia level care for up to 36 beds. There are 26 rest home level beds and 10 dementia-level beds located in a secure dementia wing. During the audit there were 21 rest home level residents and 10 dementia level residents living at this facility. There is a clear mission, core values, and strategic direction for the facility. The owner purchased the facility in January 2009. She was a registered nurse from overseas and completed the New Zealand Competency Assessment Programme (CAP) for registered nurses in 2010. Her responsibilities at the facility include maintaining certification and monitoring building compliance, contractual compliance, and environmental compliance. She is on-site three days a week, unless filling in for the nurse manager.  The full-time nurse manager is responsible for the day-to-day clinical and operational aspects of the service. She is a registered nurse with previous experience in mental health, aged care and rehabilitation.  The service is a member of CANZ (Care Association New Zealand). The professional development hours for the owner and the nurse manager that relate to the management of the service exceed eight hours per year per individual. Professional development hours relating to clinical activities also exceed eight hours per year per individual. (Professional development logbooks for the owner and nurse manager were sighted). The nurse manager reports she has recently enrolled in an 11-week dementia course through the Tasmania Open University. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the nurse manager, the owner is in charge. The owner holds a current annual practising certificate as a registered nurse. A clinical supervisor (senior caregiver) provides support to both the owner and nurse manager. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.  Policies are in place with evidence of annual reviews. If any changes occur, reviews take place more frequently, evidence on the footer of the revised policy. The facility receives policy updates from CANZ. They are up-to-date and are linked to the Health and Disability Sector Standard (HDSS), current and applicable legislation, and evidenced-based best practice guidelines. They are available electronically and in hard copy at the nurses’ station. A document control process is in place that includes a document control flow chart. The owner and nurse manager oversee the review process. New and revised policies are discussed in staff meetings.  Service delivery is monitored through incident and accident reporting, complaints management, infection control monitoring, health and safety compliance and restraint monitoring.  Monthly data is collected for falls, fractures, skin tears, medication errors, restraint use, pressure injuries and ‘other’. Data is collated, trended month to month and analysed. Findings are presented to staff in the monthly staff meetings (evidenced in the staff meeting minutes).  The internal audit programme monitors 29 key aspects of the service. An ‘Action Sheet for Audits’ is completed when corrective actions are identified. This includes recommendations, actions to be taken and sign-off by the nurse manager when completed. This form is attached to the audit form when completed. Staff meetings take place every month (meeting minutes sighted). There is evidence of audit findings and corrective actions being discussed with staff.  Achievements against the quality and risk management plan over the past year include an ‘intentional rounding’ system to analyse residents’ falls; increasing the activities in the dementia unit by increasing the hours of the activities coordinator, the development of individual residents’ activities plans and personal stories; and implementing a delirium detection and management programme  All staff interviewed four caregivers (one senior caregiver/clinical supervisor, one caregiver who works in the rest home and two caregivers who work in the dementia unit and in the rest home), one activities coordinator, one cook, and one health and safety officer report they are kept informed of quality improvements and corrective action plans. The organisation has a risk management policy in place that documents risks associated with the service, and risk minimisation strategies. The health and safety officer (owner’s spouse) has undergone his level one and level two health and safety training from an external provider. The hazard register identifies hazards. All identified hazards have controls in place to minimise, isolate and/or eliminate the hazard. The health and safety officer monitors the hazard controls every month. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The owner and nurse manager are aware of situations in which they would need to report and notify statutory authorities. The health and safety policy includes a serious harm reporting process.  Staff are encouraged to recognise and report errors or mistakes. They receive education at orientation on the incident and accident reporting process. Four caregivers (one senior caregiver/clinical supervisor, one caregiver who works in the rest home and two caregivers who work in the dementia unit and in the rest home), one activities coordinator, one cook, and one health and safety officer interviewed understand the accident/incident reporting process and their obligation to document all untoward events.  Out of the twenty incident/accident reports that were selected for review, there were fifteen injuries that occurred. There was a lack of evidence of open disclosure for each recorded event (link 1.1.9.1). Although the nurse manager signs off on each accident and incident form, there was also a lack of evidence to reflect a timely investigation of the injury by the nurse manager in seven of the fifteen completed accident/incident forms where an injury had been sustained. |

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Staff are encouraged to recognise and report errors or mistakes. They receive education at orientation on the incident and accident reporting process. Four caregivers (one senior caregiver/clinical supervisor, one caregiver who works in the rest home and two caregivers who work in the dementia unit and in the rest home), one activities coordinator, one cook, and one health and safety officer interviewed understand the accident/incident reporting process and their obligation to document all untoward events.  Out of the twenty incident/accident reports that were selected for review, there were fifteen injuries that occurred. Although the nurse manager signs off on each accident and incident form, there was also a lack of evidence to reflect a timely investigation of the injury by the nurse manager in seven of the fifteen completed accident/incident forms where an injury had been sustained. |
| **Finding:** |
| Out of the twenty incident/accident reports that were selected for review, there were fifteen injuries that occurred. Although the nurse manager signs off on each accident and incident form, there was also a lack of evidence to reflect a timely investigation of the injury by the nurse manager in seven of the fifteen completed accident/incident forms where an injury had been sustained. |
| **Corrective Action:** |
| Ensure there is evidence of the timely response by a registered nurse following an adverse event where an injury is sustained. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Copies of practising certificates were sighted for the both registered nurses (owner and nurse manager) and the GP.  Five staff files were randomly selected for review (the clinical supervisor/senior caregiver, and four caregivers). Staff undergo a comprehensive orientation programme that meets the educational requirements of the ARC contract and includes skill-based competencies. Two of the five staff (two caregivers) were employed in March 2014 and were working on completing their skills checklist. Their orientation checklists were not available for sighting. The organisation has a mandatory education programme with in-services held each month. The range of topics provided meet ARC contractual requirements that exceeds eight hours per year. Cultural education for staff is due this year (link 1.1.4). External education is provided through the Waitemata District Health Board (WDHB). The WDHB Gerontology Nurse Specialist, the WDHB Wound Care Nurse Specialist and the WDHB Dementia Care Specialist provide specialist training and consultation. The owner and nurse manager both attend aged care conferences. Caregivers undertake either the NZQA Aged Care Education or Careerforce education programmes. There are nine caregivers who work in the dementia unit. Six caregivers and the activities coordinator have completed the Careerforce Dementia Standard as per contractual requirements. Caregivers who have not completed their dementia training are enrolled in the Careerforce programme. This includes all staff who have been employed by the service for less than one year with one exception. There is one staff that has been working in the dementia unit for longer than one year and has not completed the Careerforce Dementia Standard. The nurse manager states English is this caregiver’s second language and she has had difficulty completing the course. Annual performance appraisals are conducted for all staff. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Staff rosters sighted reflect staffing levels that meet resident acuity and bed occupancy. Both the nurse manager and owner are RNs. There is one RN on call seven days a week, 24 hours per day.  Dementia Unit:  The AM shift is staffed with one caregiver, seven days a week. The activities coordinator is scheduled from 9am – 12:30pm Monday – Friday. The clinical supervisor (senior caregiver) is available if needed and supervises all of the caregivers. The PM shift is staffed with one caregiver and the night shift is staffed with one caregiver.  Rest Home The AM shift is staff with two caregivers. The PM shift is also staffed with two caregivers, one who works 3pm – 11pm and one who works 3pm – 9pm. The night shift is staffed with one caregiver.  Four of four residents and six of six relatives report that staff levels are appropriate to meet the residents’ needs. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents’ files are appropriate to the service type. Residents entering the service have the relevant initial information recorded within 24 hours of entry into the service.  Policies are in place relating to patient information. These policies are linked to the Health Information Privacy Code 1994 and the Privacy Act 1993. Individual residents’ files demonstrate service integration. Residents’ files are integrated. All six residents’ files sighted are sufficiently detailed, dated and timed. The name and designation of staff is noted for entries in the records sampled.  Current and archived records are stored securely. The records can only be removed by authorised personal.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The RN nurse manager screens all potential residents to ensure they have a needs assessment, completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. There is an information booklet for the rest home level of care and a booklet for the dementia care unit. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. Four residents (three rest home, one dementia care) and six family/whanau (four rest home and two dementia) confirm they had received all relevant information prior to or on admission. E4.1.b There is written information on the service philosophy and practices particular to the Dementia Unit (Turquoise) 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 emphasis on:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Six admission agreements sighted are signed.  D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. E3.1 Two files were reviewed and all include a needs assessment as requiring specialist dementia care |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The admission policy describes the declined entry to services process. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency and or general practitioner (GP). |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures.  D16.2, 3, 4 The nurse manager has undertaken the assessments on admission, with the initial care plan completed within 24 hours of admission in one of six resident files sampled. The clinical supervisor (senior caregiver) has completed admission assessments, initial care plans and long term care plans for five of the six resident files sampled (three rest home and three dementia care). The long term care plan is developed within three weeks in the six of six resident files sampled.  There is documented evidence of resident and/or family/whanau/EPOA involvement in the care planning process. Resident social history, activity lists and individual activity plans have been completed by the activity co-ordinator in six of six resident files sampled.  Care plans are used by caregivers to ensure care delivery is in line with the residents assessed needs. Resident files are integrated and available to care staff working within the rest home and the dementia area. Progress notes are maintained dated, shift identified and signed with designation.  There is a verbal and written handover forms (sighted) for caregivers identifying any resident needs, concerns or events. Four caregivers could describe a verbal handover at the start of each duty that maintains a continuity of service delivery.  There is a designated GP from a local health centre that visits weekly. Three monthly reviews are completed as due and any resident concerns addressed. The GP is contacted by fax with any resident health issues and the nurse manager receives a timely response. The GP (interviewed) has a good rapport with the mental health service specialist and key workers and are readily available for advice or visits as required. A locum GP provides cover as needed. The GP practice provides after hours service for the facility. The GP states the staff are organized and ready for his weekly visits and he is happy with the care and service provided to his patients.  Medical assessments are completed within 48 hours of admission by the GP in six of six resident files sampled.  The service has access to the gerontology nurse specialist and dementia nurse specialist based at the local district health board (DHB). Both specialist liaise closely with the mental health services key workers. Key workers follow up admissions under their care at least weekly until the resident is settled into their new environment. The gerontology nurse specialist provides onsite education for the staff. The crisis team respond if required. Non-clinical mobile services available include mobile dentist, bay audiology, podiatrist and optometrist  Tracer methodology; Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology; Dementia care resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The registered nurse manager has completed one initial assessment and countersigned two initial assessments completed by the clinical supervisor (senior caregiver). There is documented evidence of resident and/or family/whanau/EPOA involvement in the care planning process. Resident social history, activity lists and individual activity plans have been completed by the activity co-ordinator in six of six resident files sampled.  Care plans are used by caregivers to ensure care delivery is in line with the residents assessed needs. Resident files are integrated and available to care staff working within the rest home and the dementia area. |
| **Finding:** |
| The clinical supervisor (senior caregiver) has completed admission assessments (five), initial care plans (five), long term care plans (six) and evaluations (four) of the six resident files sampled. |
| **Corrective Action:** |
| Ensure a registered nurse completes each stage (assessment, planning, provision, evaluation, review, and exit) of provision of care. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Admission documentation obtained on interview with resident/relative or advocate 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. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered 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. Initial assessments and risk tools assessments used to form the basis of the initial care plan have not been completed by an RN in five of six resident files sampled. The risk tools reviewed six monthly as part of the review process have not been reviewed by an RN in four out of six resident files sampled (link 1.3.3.1). Two residents are not due for six monthly review.  Relatives and residents advised on interview that assessments were completed in the privacy of their single room.   A range of risk assessment tools are available for use on admission where applicable including (but not limited to); a) resident dietary profile b) coombes falls risk d) waterlow pressure area risk assessment, e) continence and bowel f) pain assessment g) wound assessment and h) disturbing behaviour assessment and monitoring chart (as applicable).  There is an improvement required around the use of formal assessment tools.  E4.2; Three of three dementia care resident files sampled did not include an individual behaviour assessment on admission identifying diversional, motivation and recreational requirements particular to the resident. There is an improvement required around behaviour assessments. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A range of risk assessment tools are available for use on admission where applicable including (but not limited to); a) resident dietary profile b) coombes falls risk d) waterlow pressure area risk assessment, e) continence and bowel f) pain assessment g) wound assessment and h) disturbing behaviour assessment (as applicable). Also link 1.3.6.1. |
| **Finding:** |
| There are no pain assessments in place for two residents (one rest home and one dementia) who identify with pain on admission. There are no disturbing behaviour assessments on admission for three dementia care residents (link E.4.2). |
| **Corrective Action:** |
| Ensure assessment tools are completed for residents who identify with pain. Ensure behaviour assessments are completed on admission for all dementia care residents. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The 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 long term care plan is developed from information gathered over the first three weeks of admission. Caregivers complete a care plan form on each new resident that is used to assist the RN to identify the resident’s abilities in activities of daily living. Care plans in place have not been developed by the RN (link 1.3.3.1). There is an improvement required to ensure the residents current needs are documented in the care plans. There is documented evidence the resident/family/whanau have input into the care planning process in six of six files sampled. Residents and family interviewed confirm they are involved in the care plan process and reviews.  The integrated resident file also contains admission documents, informed consent forms, care documents and reviews, medical documentation, test results (laboratory and radiology), allied health notes, referrals and other relevant health information, activities documentation, recordings (weight, blood pressure), and any correspondence. Notes by the GP and allied health professionals are evidenced.  D16.3f: Six of six resident files (three rest home and three dementia) reviewed identified that family were involved.  D16.3k: There is an improvement required around the use of short term care plans for changes in health status.  E4.3 Three of three dementia resident care plans reviewed, did not identify current abilities, level of independence, identified needs and alternative strategies (over a 24 hour period) based on assessment and prevention of the individuals specific behaviours. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The 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 long term care plan is developed from information gathered over the first three weeks of admission. Caregivers complete a care plan form on each new resident that is used to assist the RN to identify the resident’s abilities in activities of daily living. |
| **Finding:** |
| E4.3 Three of three dementia resident care plans reviewed, did not identify current abilities, level of independence, identified needs and alternative strategies (over a 24 hour period) based on assessment and prevention of the individuals specific behaviours. ii) One dementia resident hospitalised following seizures does not have a nursing management plan in place for seizures. iii) There is no management plan for rest home resident with angina, iv) There are no short term care plans in place for a) resident with chest infection and b) resident with shortness of breath and acute congestive heart failure. |
| **Corrective Action:** |
| Ensure care plans for dementia residents identify specific needs and alternative strategies over a 24 hour period for the management and prevention of behaviours. ii) and iii) Ensure care plans reflect the resident needs, and iv) Ensure short term needs are documented. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Milton Court provides services for residents requiring rest home and dementia level of care. When a resident's condition alters, the registered nurse manager initiates a review and if required, GP consultation. The four caregivers interviewed stated that they have all the equipment referred to in the care plans necessary to provide care, including (but not limited to), pressure relieving resources, transfer belts, mobility aids, wheelchairs, weigh scales, gloves, aprons and masks.   D 18.3. There are three minor wounds (two skin tears and one graze). Wound assessments for the three wounds are incomplete. There is no name or designation of the person completing the assessment. There is no evidence of wound monitoring in place for the three wounds. Body maps show the location of the wound. Wound care advice is readily available to the RN's. On the day of audit the DHB wound care nurse specialist (interviewed) made a courtesy visit to the service as part of the memorandum of understanding. Wound management and pressure area prevention education is provided on site for the RN’s and caregivers. There is an improvement required around wound management.  D 18.4 Continence products are available and resident files include a urinary continence assessment (where applicable), bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN nurse manager on duty could describe the referral process. There are adequate supplies of continent products in all areas. There is an improvement required around continence assessments.    Residents’ weight is recorded on admission and monitored monthly. Electronic scales are available and have been calibrated. Unintentional weight loss is monitored and the GP informed. Currently there are no residents with weight loss. Pain is identified in the long term care plan for residents who identify pain as an issue. The monitoring of the effectiveness of pain relief is documented on a pain chart and in the resident progress notes. There is no evidence of pain assessments for new or breakthrough pain episodes. Resident progress notes are written daily and for any significant events or changes in health status. There is no RN intervention or follow up for a resident with altered mood as written and highlighted in the progress notes. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are three minor wounds (two skin tears and one graze). Body maps show the location of the wound. Wound care advice is readily available to the RN's. Wound management and pressure area prevention education is provided on site for the RN’s and caregivers. Continence products are available and resident files include a urinary continence assessment (where applicable), bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the RN nurse manager on duty could describe the referral process. There are adequate supplies of continent products in all areas. Pain is identified in the long term care plan for residents who identify pain as an issue. The monitoring of the effectiveness of pain relief is documented on and in the resident progress notes. Resident progress notes are written daily and for any significant events or changes in health status. There is no RN intervention or follow up for a resident with altered mood as written and highlighted in the progress notes. |
| **Finding:** |
| (i)Wound assessments are incomplete and there is no evidence of wound monitoring. (ii) There is no continence assessment or continence management plan in place for a dementia care resident with recent reports of incontinence. (iii) There is no pain assessment or documented interventions for a) dementia resident with a new episode of knee pain and b) one rest home resident with an exacerbation of chronic pain. (iv) There is no RN intervention or follow up for a resident (previously under mental health services) with altered mood as written and highlighted in the progress notes. |
| **Corrective Action:** |
| (i) Ensure wound care documentation is completed as per policy. (ii) Ensure continence assessments and management plans are in place where applicable (iii) Ensure pain assessments are completed for new episodes of pain and breakthrough pain to identify strategies to manage. (iv) Ensure there is RN review of progress notes to ensure appropriate interventions are implemented for significant events. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activity co-ordinator has been with the service for six years and is employed five hours a day Monday to Saturday each week. An activity assistant/reliever provides assistance as required for outings and drives. A consultant diversional therapist provides advice, guidance and up to date information to the team as required. The activity co-ordinator meets with the manager regularly and attends staff meetings. She attends on-site education sessions and holds a current first aid certificate. The activity co-ordinator has separate activity programmes for the rest home and dementia care residents. Both programmes are flexible and the activities reflect interests and skills that are meaningful to the residents. The activity co-ordinator spends from 9am -12noon with the dementia residents and from 1-3pm in the rest home area. On the day of audit the ladies in the dementia wing are participating in flower arranging and sensory activities while the men are sanding down and cleaning furniture and gardening within the safe garden and grounds. One on one time is spent with individuals such as grooming, massage, reminiscing and reading. Small group activities include gardening, ball exercises and pet therapy. Rest home residents enjoy group activities and shopping and library outings. Music and entertainment is available. There are regular church visitors. Festive occasions and theme days are celebrated. There are resources available for staff to use after hours and at the weekends. There are van outings on Saturdays.  A life history is completed for each resident/family/whanau describing their past and resent interests, hobbies and community links. An activity plan is developed that is appropriate to their needs, abilities, skills, interests and cognitive function. Activity progress notes are maintained in the integrated file.  D16.5d There is a plan in place to coordinate the review of all the individual activity plans at the time of residents long term 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The initial assessments and initial care plan is evaluated and the long term care plan developed within three weeks of admission. Four of six resident files evidence long term care plans evaluated at least six monthly. Two residents (dementia level) have not been at the service long enough for a review. There is a three monthly physical examination and medication review by the GP.  Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going (also link 1.3.5.2).  D16.4a; Care plans are evaluated six monthly.  ARC: D16.3c; Initial care plans in one of six resident files has been evaluated by the RN. In five of six files the initial care plans have been evaluated by the clinical supervisor (senior caregiver). (link 1.3.3.1) |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The nurse manager described the referral process to other medical and non-medical services. All specialist referrals are initiated by the GP. Referral documentation is maintained on resident files. The nurse manager initiates referrals to nursing and non-medical services through the DHB with the use of their referral forms where applicable.  D16.4c: The service currently does not have any residents requiring a re-assessment of a resident’s condition for a higher level of care. D 20.1; Discussions with the nurse manager identified that the service has access to including (but not limited to), wound care nurse specialists, incontinence specialists, podiatrist, gerontology nurse practitioner, dementia nurse specialist, mental health services for the older person and occupational therapist. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There are associated transfer papers to complete as per the yellow envelope checklist for residents transfers to the district health board (DHB) services. 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. All transfers to and from higher levels of care is co-ordinated by the needs assessment team. 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 communication notes 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.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The main medication room is located within the rest home wing. A locked medication trolley is kept in the dementia wing dining area. Monthly blister packs are delivered to the facility and checked on delivery. Medication reconciliation form sighted. Returns are stored in the locked medication room until collected. The nurse manager, owner/RN and caregivers complete annual medication and controlled drug competencies annually. This includes a questionnaire and practical audit of medication administration. The controlled drug safe is located in the rest home locked medication room. There is currently one resident on controlled drugs. There is no evidence of weekly controlled drug physical stocktakes undertaken by a RN and one other medication competent person. Expiry dates are checked of all stock. Faxed pharmacy orders are retained. Any medications requiring refrigeration is stored in a separate sealed container in the kitchen fridge. Fridge temperatures are monitored. Standing orders are not used. There are three residents self-medicating inhalers in the rest home. Self-medication competencies have been completed and are reviewed by the RN. Monitoring is in place. Medication charts and signing sheets are in separate folders. This is corrected on the day of audit with medication charts and signing sheets integrated in one folder. Twelve medication charts (six rest home and six dementia) are sampled. All medication charts have photo identification and allergies noted. PRN medications are dated and timed on administration. There are no gaps in the signing sheets. Medication charts (12) have been reviewed by the GP at least three monthly. Four out of 12 medication charts require an indication for use of prn medications charted. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Twelve medication charts (six rest home and six dementia) are sampled. All medication charts have photo identification and allergies noted. Medication charts (12) have been reviewed by the GP at least three monthly.  The nurse manager, owner/RN and caregivers complete annual medication and controlled drug competencies annually. This includes a questionnaire and practical audit of medication administration. The controlled drug safe is located in the rest home locked medication room. There is currently one resident on controlled drugs. |
| **Finding:** |
| (i)Four out of 12 medication charts require an indication for use of prn medications charted. (ii) There is no evidence of weekly controlled drug physical stocktakes undertaken by a RN and one other medication competent person. |
| **Corrective Action:** |
| (i)Ensure prn medication prescribed have an indication for use. ii) Ensure weekly controlled drug physical stocktake is completed. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employs a cook from 7am-1pm daily and an afternoon kitchen hand from 4pm to serve the evening meal. The cook (interviewed) has been in the role three weeks and has completed a food handling certificate (4 April 2014). He has had previous experience in the food industry. There is a rotating three weekly summer and winter menu that has been recently reviewed by the dietitian (2 April 2014). There is a hot midday meal. The kitchen is located adjacent to the rest home and meals are served directly to the residents. Meals are plated with heat lids and taken by trolley to the dementia unit dining room. Meals are observed to be well presented. Residents interviewed are complimentary of the meals and have the opportunity to feed back on the meals at resident meetings. Nutritious snacks such as sandwiches, yoghurts and desserts are available after hours for dementia and rest home residents. The cook is aware of resident likes, dislikes and any special dietary requirements. Resident dietary profiles are received for new admissions and there is evidence six monthly reviews. All dry goods stored in the pantry are in sealed labelled containers. Foods in the fridge are date labelled. Fridge and freezer temperature monitoring is recorded daily. Hot food temperature is monitored monthly. A recommendation is to increase the frequency of hot food monitoring (in line with current best practice) delegating this responsibility to the cook. There are regular cleaning duties completed. The chemicals are stored safely within the kitchen. Food services is a regular agenda item at staff meetings. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are in place and implemented for the safe and appropriate storage and disposal of waste and hazardous substances. The service has an emergency plan for the management of waste and hazard incidents or accidents. Sharps are disposed of into an approved container. There is an accident/incident system for investigating and recording all incidents. All completed forms are reviewed by the manager/owner. Staff are aware of their responsibilities relating to reporting and recording any incidents as confirmed on interview with four caregivers.  On audit day staff are observed wearing appropriate protective equipment including aprons and gloves and goggles. Chemicals are stored in locked staff only designated areas. Chemical bottles sighted have correct manufacturer labels. Safety Data Sheets (MSDS) are available for all chemicals used and outline appropriate first aid procedures. Training in the management of waste and hazardous substance and chemical safety occurs at orientation and on an on-going basis. Cleaners have attended chemical training.  General waste is removed by waste management contractor. Recycling of tins, plastics, newspapers and cardboard occur. |

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

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

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

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A current Building Warrant of fitness expires 1 June 2014. Milton Court is a 26 bed rest home and 10 bed dementia care facility. The rest home area is divided into two wings (Averill and Topaz). There is keypad entry and access to the dementia wing (Turquoise).   All resident bedrooms have hand basins. Monthly hot water temperature monitoring in resident rooms is stable between 43-45 degrees Celsius.  There are handrails in all hallways that enable residents to move around the facility safely. Doorways are kept clear of hazards. There is a maintenance person 15 hours a week. A maintenance record and request form is used for maintenance requests. Corrective actions are sighted. There is a monthly safety checklist that includes checks on carpets, handrails, ramps, hallways and floors. There are six monthly equipment checks. Electrical equipment has been tested and tagged March 2014. The stand on scales and clinical equipment has been checked January 2014. On-going maintenance includes painting, gardens and grounds. There are security gates at the entrance of the facility. Entry is by call bell. The keypad number is displayed for visitors and residents to freely exit the facility.  There are safe outside areas that are easy to access for residents and family/whanau members. These include outdoor shade, tables and chairs. There is a safe garden and grounds area for dementia residents. There is a designated resident smoking area however this is not located far enough away from the building to prevent other residents from being affected by smoke fumes.   D15.3d The lounge areas are designed so that space and seating arrangements provide for individual and group activities.  ARC D15.3; The following equipment is available, pressure relieving resources, transfer belts, mobility aids, wheelchairs, weigh scales, gloves, aprons and masks. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a designated resident smoking area. |
| **Finding:** |
| The designated resident smoking area is not located far enough away from the building to prevent other residents from being affected by smoke fumes |
| **Corrective Action:** |
| Ensure the designated resident smoking area does not adversely affect other residents. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms have hand basins. The double rooms (two) have ensuites. There are adequate numbers of communal showers and toilets at the facility. Flooring in bathrooms and toilets is of a non-slip surface and easily cleaned. Appropriate signage, vacant/occupied and privacy locks on doors were sighted. Hand washing and drying facilities are located in all service areas and toilets. Residents interviewed state staff ensure personal privacy is provided when attending to their hygiene cares or entering the bedrooms. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has 24 rest home bedrooms (two are double rooms) and 10 single bedrooms in the dementia wing. Currently there are no residents sharing bedrooms. Bedrooms viewed are personalised and residents and family members interviewed state they are encouraged to personalise their bedrooms. There is adequate space for residents to safely move around in their room with the use of mobility aids as required. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are lounges and a spacious dining room in the rest home area. The communal lounges have comfortable and appropriate seating that is placed to allow for group and individual activities to occur. The lounges and the dining room for the rest home are clearly defined as separate rooms and used for recreational activities. Staff assist residents to access communal living areas as required. Sunny outdoor areas provide as an alternative recreational area. Residents can use their bedrooms or the outdoor areas, if they require privacy at any time. There is an open plan dining, lounge and recreational area in the dementia area. There is sufficient seating and space to accommodate the residents. There is safe access to all communal areas. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a laundry worker from 7-9am daily to commence the sorting and washing of linen and personal washing. Laundry duties are then shared by the caregivers on duty. The laundry is well equipped and has a defined dirty/clean area and sluice tub. There are designated locked cleaning cupboards. There is a chemical dispensing unit for the refill of chemical bottles. Cleaners are employed Monday to Sunday in the mornings to carry out the cleaning duties. Staff are observed wearing correct personal protective equipment. Vax machines are available on site for carpet cleaning. Commercial cleaners are used as necessary. Safety data sheets are available. Chemical bottles are labelled correctly. The laundry and cleaning service are regular agenda items at staff meetings. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Emergency and disaster policies and procedures are in place. The New Zealand Fire Service approved the fire evacuation plan on 21 June 1996. A fire drill takes place six-monthly with the most recent drill occurring in October 2013 during the staff meeting. The orientation programme includes fire and security training. Staff (four caregivers, one activities coordinator, one cook, and one health and safety officer) confirm their understanding of emergency procedures.  All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. A back up three- hour battery for emergency lighting is in place.  There is a required improvement relating to the lack of a call system. The system that was previously in place has been decommissioned. The calls bells located in the toilets still have cords attached but do not work. There are no call devices attached to the outlets in the bedrooms. A pager system has been implemented to replace the previous call system. During the audit, pagers were either not found or were not within reach of the residents.  This is a secure facility, surrounded by a gate with key pad access. External lighting is adequate for safety and security. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The call system that was previously in place has been disconnected and replaced with a mobile pager system for the residents to use when assistance is required. During the audit, pagers were either not located by the auditors, or in an inaccessible location for the resident to use. Rest home level residents interviewed were unsure where their pagers were. Cords that were attached to the previous call system were still in place in the toilets but did not sound any alarm when pulled. The owner reports that she has been planning to replace the call system for some time and is looking at the various options available. |
| **Finding:** |
| An appropriate call system for this rest home and secure dementia unit is not in place. |
| **Corrective Action:** |
| Ensure residents have access to an effective call system to summon assistance when needed. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility provides adequate natural light, ventilation and heating for residents, staff and visitors. All residents' bedrooms and all communal areas are heated by safe individual heating units that are thermostat controlled. All resident communal areas and bedrooms have external windows. Three rest home residents interviewed confirm that an appropriate temperature is maintained throughout the facility |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint minimisation and safe practice policies and procedures are in place. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.  A gate surrounds the facility with keypad access only to enter and leave the grounds. Rest home level residents and families were observed leaving and entering the facility through the gate. Interviews with three rest home level residents confirm they come and go as they please. Keypad access is required to exit the dementia unit. Enablers are voluntary and the least restrictive option. There were no residents using a restraint or an enabler during this audit. Restraint training is included in the induction and two-yearly in-service education programme. The last education session was held on the 5th and 7th September 2012 and included managing challenging behaviours. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There are infection control policy and procedures developed by an external consultant. There is an established and implemented infection control programme. The 2013 infection control programme has been reviewed. The 2014 draft infection control programme is linked to the annual quality risk plan. The quality risk plan is due to be finalised at the next management meeting.  The nurse manager is the Infection Control Coordinator. The role and responsibility of the infection control co-ordinator is defined within the nurse manager job description.  The infection co-ordinator reports to the management meeting with representatives of owners, clinical, cleaning and food services staff. Infection control is a set agenda item at staff meetings monthly. Minutes are available for staff. There have been no outbreaks. Hand sanitizers are available at all entrances. Residents are strongly encouraged to have annual influenza vaccinations. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The I.C. coordinator is the nurse manager. The Infection Co-ordinator attends the management and staff meetings and provides monthly reports on infection control matters, statistics, trends, corrective actions and quality improvements. Infection Control Coordinator has access to the GP, laboratory, pharmacist, infection control nurse specialist at the DHB and the gerontology nurse at the DHB. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection control manual which includes policies and procedures appropriate to for the size and complexity of the service. The policies and procedures are developed by an external consultant and last reviewed April 2012. Any changes or updates to the infection control policies are notified at the staff meetings. All staff sign to declare they have read new and reviewed policies and procedures.  There are policies and procedures that include but are not limited to a) hand hygiene b) antimicrobial usage c) transmission based precautions; d) accidental exposure to blood e) healthcare waste, f) definitions of infections g) outbreak management. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator, who is the nurse manager, is responsible for coordinating/providing education and training to staff. The staff orientation includes specific training for infection control in particular hand washing and standard precautions. Education records of attendance at infection control training are maintained in the staff education folder. Infection Control is included in the staff orientation. The IC Coordinator attended a training day in 2010 with the IC nurse specialist and in 2013 attended a study day (including infection control) with the DHB gerontology nurse. Overheads from the training sessions are utilised for staff training last provided February 2014.  Information is provided to residents and visitors that are appropriate to their needs. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an infection control surveillance policy in place, which outlines the purpose and methodology for the surveillance of infections.  Definitions of infections are in place appropriate to the complexity of service provided. Surveillance types include urinary tract infection (UTI), skin and soft tissue, oral, eye, respiratory and vomiting and diarrhoea. Infection control data is collated monthly and includes a monthly laboratory report of organisms. A monthly infection analysis identifies trends and corrective actions/quality improvements implemented. An example is in January 2014 there were 3 UTI’s. Weekly urinalysis was commenced for high risk residents for UTI’s. Early non-pharmalogical interventions had reduced the UTI infection rate to zero in February and March 2014.  The IC Coordinator summarises the infections each month and provides an IC monthly report at the management and staff meetings.  The infection control programme is monitored by surveillance of infections and by infection control audits. Corrective actions are completed and results are reported to the management and staff meetings. |

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

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

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

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

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

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