# New Vista Rest Home Limited

## Current Status: 1 May 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

New Vista Rest Home and Hospital provides residential care for up to 52 residents who require hospital and rest home level care. Occupancy on the day of the audit is at 51. The facility is operated by New Vista Rest Home Limited. Staffing is very stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.

A new 13 bedroom wing has been created since the last audit and is reviewed as part of this audit.

There have been no changes to the staffing structure, management or systems since the last audit. Continuous improvements have been noted during this audit relating to all aspects of service delivery. There are no areas identified as requiring improvement during this audit.

## Audit Summary as at 1 May 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 1 May 2014

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

### Organisational Management as at 1 May 2014

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

### Continuum of Service Delivery as at 1 May 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 1 May 2014

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

### Restraint Minimisation and Safe Practice as at 1 May 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 1 May 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 1 May 2014

### Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirm that their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights and the facility’s processes if these are not met.

During interview residents and family confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and are fully informed. Time is provided if discussions and explanation is required. Two advocates are available for residents and visit on a regular basis. One of these advocates is interviewed during this audit and confirms that residents advise them they are well looked after and that their rights are respected.

The facility manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' meetings.

### Organisational Management

New Vista Rest Home Limited is the governing body and is responsible for the service provided at New Vista Rest Home and Hospital (New Vista). A range of key planning documents are reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at New Vista, including regular monthly reporting by the facility manager to directors.

The facility is managed by a suitably qualified and experienced facility manager who is an enrolled nurse and who has been in this current role for the last two years. The facility manager is supported by an experienced registered nurse / clinical nurse leader who has been in their current role for two years.

A full time quality manager is employed to oversee the quality and risk management systems in place at New Vista. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and corrective actions are implemented to improve service delivery. There is an internal audit programme in place. A range of risks are identified and managed. Adverse events are documented on accident/incident forms and there is evidence of notification to families following adverse events or changes in a resident’s condition.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, the pharmacist, dietitian, podiatrist, and general practitioners is occurring. There is evidence available indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) education modules. Review of staff records provides evidence that human resources processes are followed as required (e.g., reference checking, criminal history vetting, interview processes for appointment and individual education records are maintained).

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager and clinical nurse leader are on call after hours. All care staff interviewed report there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

### Continuum of Service Delivery

New Vista Rest Home and Hospital has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery.

Residents and family interviewed confirm their input into assessment, care planning and access to a typical range of life experiences and choices.

Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs.

A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

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

There is an appropriate medicine management system in place. Policies and procedures clearly detail service provider’s responsibilities. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies.

There are four residents who self-administer medicines, and do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. The facility has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. There was positive feedback from residents about the food service.

### Safe and Appropriate Environment

A new wing with13 single bedrooms with full ensuite facilities, a new lounge and hairdressers room have been built since the last audit. These bedrooms are able to be used by either rest home or hospital level residents. The remainer of the facility provides one double bedroom and the rest of the bedrooms provide single accommodation for residents. The majority of the bedrooms have been full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility.

Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There are separate lounges and dining areas throughout the facility. External areas are available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and is used by staff.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

### Restraint Minimisation and Safe Practice

The service has an overarching risk and quality management system that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive.

The facility is currently using 12 restraints and four enablers.

Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed, monitoring of restraint is occurring and each episode of restraint is being evaluated.

### Infection Prevention and Control

The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.

New employees are provided with training in infection control practices and there is on-going education available for all staff.

Infection control is a standard agenda item at staff and quality meetings. Staff interviews confirm staff are familiar with infection control measures at the facility.

Surveillance for residents who develop infection are collated at the end of each month and reported on monthly.

# 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**

|  |  |
| --- | --- |
| **Legal entity name:** | New Vista Rest Home Limited |
| **Certificate name:** | New Vista Rest Home Limited |

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| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | New Vista Resthome & Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 1 May 2014 | **End date:** | 2 May 2014 |

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| **Proposed changes to current services (if any):** |
| Reconfiguration of service by redeveloping an existing seven bedrooms that were used by rest home residents into bedrooms that can be used by either rest home or hospital residents. Reconfiguration of this area also includes building an additional six bedrooms that can be used for either rest home or hospital level services as required. A new lounge is created as part of this rebuilding project. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 51 |

## **Audit Team**

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| **Lead Auditor** | XXXXX | **Hours on site** | 12.5 | **Hours off site** | 8.5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12.5 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 25 | Total audit hours off site | 15.5 | Total audit hours | 40.5 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 50 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) 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 Audit (NZ) Limited | Yes |
| b) | Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Tuesday, 6 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| New Vista Rest Home and Hospital provides residential care for up to 52 residents who require hospital and rest home level care. Occupancy on the day of the audit is at 51. The facility is operated by New Vista Rest Home Limited. Staffing is very stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.   A new 13 bedroom wing has been created since the last audit and is reviewed as part of this audit.  There have been no changes to the staffing structure, management or systems since the last audit. Continuous improvements have been noted during this audit relating to all aspects of service delivery. There are no areas identified as requiring improvement during this audit. |

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| **Outcome 1.1: Consumer Rights** |
| The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents’ and their families on admission to the facility. Residents and family members interviewed confirm that their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights and the facility’s processes if these are not met. During interview residents and family confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and are fully informed. Time is provided if discussions and explanation is required. Two advocates are available for residents and visit on a regular basis. One of these advocates is interviewed during this audit and confirms that residents advise them they are well looked after and that their rights are respected. The facility manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' meetings. |

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| **Outcome 1.2: Organisational Management** |
| New Vista Rest Home Limited is the governing body and is responsible for the service provided at New Vista Rest Home and Hospital (New Vista). A range of key planning documents are reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at New Vista, including regular monthly reporting by the facility manager to directors.   The facility is managed by a suitably qualified and experienced facility manager who is an enrolled nurse and who has been in this current role for the last two years. The facility manager is supported by an experienced registered nurse / clinical nurse leader who has been in their current role for two years.  A full time quality manager is employed to oversee the quality and risk management systems in place at New Vista. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and corrective actions are implemented to improve service delivery. There is an internal audit programme in place. A range of risks are identified and managed. Adverse events are documented on accident/incident forms and there is evidence of notification to families following adverse events or changes in a resident’s condition.  There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, the pharmacist, dietitian, podiatrist, and general practitioners is occurring. There is evidence available indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) education modules. Review of staff records provides evidence that human resources processes are followed as required (e.g., reference checking, criminal history vetting, interview processes for appointment and individual education records are maintained).   There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager and clinical nurse leader are on call after hours. All care staff interviewed report there is adequate staff available.   Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| New Vista Rest Home and Hospital has a documented entry criteria, which is communicated to residents, family and referral agencies.  Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery.   Residents and family interviewed confirm their input into assessment, care planning and access to a typical range of life experiences and choices.  Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services. Residents interviewed confirm that interventions noted in their care plans are consistent with meeting their needs.   A sampling of residents' clinical files validates the service delivery to the residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Residents and family interviewed confirm their participation in these evaluations. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.  Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis.  There is an appropriate medicine management system in place. Policies and procedures clearly detail service provider’s responsibilities. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies.  There are four residents who self-administer medicines, and do so according to policy.  Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. The facility has a central kitchen and on site staff that provide the food service. Kitchen staff have completed food safety training. A four week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. There was positive feedback from residents about the food service. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| A new wing with13 single bedrooms with full ensuite facilities, a new lounge and hairdressers room have been built since the last audit. These bedrooms are able to be used by either rest home or hospital level residents. The remainer of the facility provides one double bedroom and the rest of the bedrooms provide single accommodation for residents. The majority of the bedrooms have been full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility.   Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There are separate lounges and dining areas throughout the facility. External areas are available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.  There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and is used by staff.  Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has an overarching risk and quality management system that demonstrates compliance with the Standard. Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are least restrictive. The facility is currently using 12 restraints and four enablers. Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed, monitoring of restraint is occurring and each episode of restraint is being evaluated. |

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| **Outcome 3: Infection Prevention and Control** |
| The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection, and contains all requirements in the standard, with policies and procedures to guide staff in all areas of infection control practice.  New employees are provided with training in infection control practices and there is on-going education available for all staff. Infection control is a standard agenda item at staff and quality meetings. Staff interviews confirm staff are familiar with infection control measures at the facility. Surveillance for residents who develop infection are collated at the end of each month and reported on monthly. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive training in the Code of Health and Disability Services Consumers’ Rights’ (the Code) at least annually (records sighted). Care staff are observed interacting respectfully and communicating appropriately with residents. Staff allow residents to make choices demonstrating their knowledge of residents’ rights.   Residents (three hospital and five rest home) and family members (three hospital and three rest home) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey results.  Interviews with staff (one registered nurse / clinical nurse leader, three registered nurses, three care givers and one diversional therapist) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided on 04 December 2013.  The district health board contract requirements are met. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the information pack provided on admission to the facility.   Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility’s admission package, which is reviewed, prior to the resident’s admission. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.  The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement and eight admission agreements are reviewed and all are found to contain this level of information.  Residents interviewed confirm they have access to an independent advocate may be appointed if needed. Resident meeting minutes dated 18 February 2014 reviewed and indicates one of the two independent advocates discussed their role as an independent advocate during this meeting as well as discussing the Code.   The district health board contract requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **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:** |
| Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents (three hospital and five rest home) and family members (three hospital and three rest home) and during review of resident satisfaction surveys.  Staff receive training on abuse / neglect and the last education session for staff was provided in August 2013. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents.   Activities in the community are encouraged and several residents attend community events independently. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.  Values, beliefs and cultural aspects of care are recorded in residents’ clinical files reviewed (four hospital and four rest home).   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).   There are two residents in the facility that identify as Māori and their files are reviewed during this audit. A ‘Cultural Awareness Whare Tapa Wha: Holistic Model Within Māoridom’ assessment and care planning tool is used for residents who identify as Māori and are reviewed on the files for the residents who identify as Māori.   Access to Māori support and advocacy services is available if required via family members of residents and from Kuia and Kaumatua from the different local iwi. A list of contacts for the various iwi groups is maintained and is reviewed.  Family members (two) are interviewed and confirm their involvement in the care of their family member. Interview of one resident and family member confirms their cultural values and beliefs are met.  Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education was last provided on 29 October 2013.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documentation reviewed during this audit provides evidence that appropriate culturally safe practices are implemented and are being maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation reviewed lists the details on how to access appropriate expertise (e.g. cultural specialists, and interpreters).  Residents' files reviewed demonstrate that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. All residents have a cultural assessment completed as part of the care planning process.   Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the resident/relative satisfaction surveys completed (monthly to a random sample). Church services are held on site on a regular basis as part of the activities programme.  Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.  The district health board contract requirements are met. |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a code of conduct that includes house rules. These documents also address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on staff files (seven).   A review of the accident/incident reporting system, complaints register and interview of the facility manager indicates there have been no allegations made against staff alleging unacceptable behaviour.   Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to. |

##### **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:** |
| Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provides evidence that policies and procedures are based on evidence-based rationales.   Education is provided by specialist educators as part of the in-service education programme and this is confirmed during review of education records and interview of the facility manager, quality manager, the clinical nurse leader and registered nurses (three) who describe the process for ensuring service provision is based on best practice, including access to education by specialist educators. The facility manager and clinical nurse leader advise the district health board (DHB) specialist nurses provide education and support for the clinical staff as needed. The also advise that the registered nurses (RNs) and enrolled nurses (ENs) attend compulsory education at the DHB and are completing the professional development recognition programme (PDRP) via the DHB.  Staff interviewed confirm understanding of professional boundaries and practice.   The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed. Residents' files reviewed (four rest home and four hospital) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.    Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff who are responsible for their care.  The facility manager advises access to interpreter services is available if required via the local community, family members and interpreter services if required. They also advise there are no residents currently in New Vista who require interpreter services.   The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Eight admission agreements are reviewed and this was clearly communicated in each agreement.   The district health board contract requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The facility manager, clinical nurse leader and RNs report informed consent is discussed and is recorded at the time the resident is admitted to the facility.   Residents/family are provided with various consent forms on admission for completion as appropriate and are reviewed on eight resident’s files (four rest home and four hospital). Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident’s files.  Staff interviewed (three care givers, three RNs, the facility manager and the clinical nurse leader) demonstrate a good understanding of informed consent processes.   Residents (three hospital and five rest home) and family (three rest home and three hospital) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.   Residents' files (four rest home and four hospital) reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights and was last provided on 04 December 2013.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.   Resident meetings are held two monthly for each area and minutes are reviewed that and provide evidence of discussion on the Code with residents by one of the two independent advocates. One of the two advocates is interviewed during this audit and confirms they visit the facility at least weekly to provide advocacy and pastoral support for residents.   Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, and complaint management as part of the in-service education programme. This was confirmed during review of staff education records.   Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the Nationwide Advocate details are displayed along with advocacy information brochures. The admission pack is reviewed and provides evidence of advocacy, complaints and Code of Rights information is included.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service (e.g. visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs, including reading of the newspaper each day.  Residents and family members interviewed confirm they can have access to visitors of their choice, and confirm they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van with a hydraulic lift is available to take residents on community visits. Some residents go out independently on a regular basis.   Residents' files reviewed demonstrate that activity plans identify support/interest groups. Progress notes and care plan content includes regular outings and appointments (records sighted).  The district health board contract requirements are met. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate systems in place to manage the complaints processes and these are reviewed during this audit. A complaints register is maintained at the facility, and there are two complaints recorded in the complaints register for 2014 and three for 2013. Reporting of complaints occurs at the monthly quality meetings, via the monthly quality reports and monthly facility manager's report to the directors. The facility manager reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. The Health and Disability Commissioner complaint that was received in August 2011 was closed off by the Health and Disability Commissioner in December 2013.  Complaints policies and procedures are reviewed and are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents / their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of residents’ ability to raise any issues they have, and this was confirmed during interviews of residents.  A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of quality improvement meeting minutes, registered nurse/enrolled nurse, staff meeting minutes and monthly manager’s reports to the directors provide evidence of reporting of complaints.  The district health board contract requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| New Vista Rest Home Limited (NVRHL) is the governing body and there are robust quality and risk management systems in place. A ' New Vista Rest Home & Hospital Business Plan July 2013 – June 2015’ and 'New Vista Risk Management Plan’ are reviewed and includes a mission statement, core values, key result areas, quality objectives and scope of service. NVRHL has established systems in place which defines the monitoring and reporting processes against the business plan and the risk management plan. The monitoring systems include regular monthly reporting by the facility manager and the quality manager to the governing body and some of these reports are reviewed.  Documented values, mission statement and philosophy are also reviewed and these are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.  Meeting schedules and minutes reviewed provide evidence that monthly quality, RN and EN meetings and ward meetings are held. Combined staff meetings are held three monthly and resident meetings are held two monthly. Meeting minutes are available for review by staff along with quality reports, clinical indicator reports and graphs of clinical indicators.   The facility manager, who is an enrolled nurse, was appointed in May 2012 and has extensive aged care and management experience. The facility manager is supported by a clinical nurse leader (CNL), who is an experienced registered nurse and who was appointed in August 2012. The CNL is responsible for the management of clinical care for residents. The management team also includes an experienced quality manager and two registered nurse clinical care co-ordinators.   The facility manager and clinical nurse leader’s personal files and education records are reviewed and provide evidence of maintaining knowledge and current practice and both have current annual practising certificates.  New Vista Rest Home and Hospital is certified to provide hospital and rest home level care and on the day of this audit there are 29 hospital level residents (including one aged less than 65 years assessed as requiring hospital level care) and 22 rest home level care residents. New Vista Rest Home Limited has contracts with the DHB to provide aged related residential care, chronic health conditions, carer relief, respite care, intermediate care (transitional care), and residential non-aged services.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager (FM) be absent. The clinical nurse leader (CNL) and the quality manager fill in for the FM if they are absent and both are interviewed during this audit. One of the senior RNs / clinical care co-coordinators assumes responsibility for clinical management if the CNL is absent. The directors are also available for support if required.   Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the FM and CNL confirm their responsibility and authority for their roles.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A quality and risk management plan and business plan are used to guide the quality programme and include quality goals and objectives. New Vista has an established and documented quality and risk management system that is maintained to a high standard.   There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to the governing body / directors via monthly manager’s and quality reports. Quality improvement meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. RN/EN meetings, unit meetings and combined staff meeting minutes are reviewed and also provide evidence of reporting of quality improvement data.  Various quality registers and documentation is reviewed and provides comprehensive evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality, staff, RN/EN meetings. Resident meetings are held two monthly. The monthly reports to the directors include copies of all meeting minutes as well as monthly quality reports and graphs of quality improvement data. Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are being developed, implemented and reviewed.   Staff interviewed report they are kept informed of quality and risk management issues including clinical indicators. Staff interviewed report this information is discussed with them at hand-over between shifts and during their meetings. This information is also reviewed in the staff newsletters. Copies of meeting minutes are available for staff to review in the staff offices and include graphs of clinical indicators.   Resident and family satisfaction surveys are completed monthly and collated results reviewed. Different residents/family members are surveyed each month and the results are collated at the end of each month. The results are reported via the monthly quality meetings, managers’ reports and a copy of the collated results is displayed on the residents’ notice board. Any areas identified as requiring improvement during these surveys are addressed immediately. Month by month comparisons are made of the residents feedback and review of this data and individual responses indicates high levels of resident satisfaction. A ‘Short term and post admission follow-up survey’ of residents is also undertaken and the results for 2014 are reviewed during this audit.   Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service and reflects current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Policies and procedures are reviewed by the quality manager following consultation with clinical personnel. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.   A health and safety manual is available that includes relevant policies and procedures and is reviewed during this audit. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed and all biomedical equipment have appropriate performance verified stickers in place and/or calibration reports.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an 'Accident/ Incident Form' which are reviewed by the registered nurse and the clinical nurse leader and are then recorded on an ‘Incident/Accident Analysis Form’ which is a register of events and 2013 and 2014 data is reviewed. Corrective action plans to address any areas identified as requiring improvement are documented on the 'Accident/ Incident Form' and there is evidence of monitoring of this.  Eight resident’s (four hospital and four rest home) files reviewed and there is evidence that families are being contacted following adverse events involving the resident, or when there is any change in the resident’s condition.   Accident and incident forms, residents progress notes, and family communication sheets provide evidence that communication/contact with family is being documented following adverse events (as appropriate) involving the resident, or when there is any change in the residents condition. Family members interviewed during this audit advise they are contacted if their family member has an accident/incident, and/or if there is any change in their condition.  Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions; policies and procedures; and professional codes of conduct, which this is confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (e.g., health and safety, human resources, infection control).   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Written policies and procedures in relation to human resources management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (seven of seven) along with  reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments (as appropriate), and annual practising certificates for the registered nurses and enrolled nurses. Copies of annual practising certificates are also reviewed for staff that require them to practice.  The facility manager (FM) is responsible for management of the in-service education programme and there is evidence available indicating in-service education is provided for staff at least once a month. The education planners for 2013 and 2014 are reviewed and provide evidence that ongoing education is provided. A competency register is maintained and the registers for 2013 and 2014 are reviewed during this audit and indicate staff have current competencies in place as appropriate.  Staff are supported to complete the Aged Care Education (ACE) modules and an external contractor, who is a registered nurse, comes on site at least two weekly to assist staff with completion of the ACE modules. Individual records of education are maintained for each staff member and copies are reviewed on an electronic database. An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed.   An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The FM advises that staff are orientated for at least three shifts (morning and afternoon shifts) at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (i.e., the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation’s vision, values & philosophy).  Care staff interviewed (three caregivers working both rest home and hospital in the rest home and/or the hospital) and three RNs working all three shifts) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and the currency of their performance appraisals.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale (Staffing Rationale Policy) for determining service provider levels and skill mixes in order to provide safe service delivery. Twenty four hour registered nurse cover is provided. The minimum amount of staff is provided during the night shift and currently consists of one registered nurse and two caregivers. The clinical nurse leader is available after hours for clinical issues, and the facility manager for business/administration issues if required.   The service provider uses a 'Models of Care' tool that allocates a set number of care staff hours per resident in the rest home and in the hospital that is based on best practice and indicates the hour’s variance on a day by day basis. This is reviewed during this audit.  All care staff interviewed report there is adequate staff available and that they are able to get through their work. Care staff report they work well as a team to provide assistance to each other. Residents (five rest home and three hospital) and family (three rest home and three hospital) interviewed report there is enough staff on duty to provide them with adequate care.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident information is entered in an accurate and timely manner into a register (electronic) that is appropriate to the service and is in line with legislative requirements. Interview with the quality manager confirms the resident details are entered onto an electronic record on the day of admission.  Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provide evidence that an entry into the resident’s clinical record is made on each shift and entries are clear, dated and signed.   A visual inspection of the facility provides evidence that residents' information is stored in staff areas and is held securely and is not on public display. Clinical notes are current and are accessible to all clinical staff. The resident's NHI number, name, and date of birth are used as the unique identifier.   Clinical staff interviewed three RNs and three care givers), the clinical nurse leader and the facility manager confirm they know how to maintain confidentiality of resident information. Historical records are held securely on site and are accessible.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy and procedures for entry criteria, assessment and entry screening are recorded and implemented. The service provides information to potential referral sources. This facility operates 24/7.   Eight of eight residents' files (four rest home and four hospital) are sampled, including residents' admission agreements. All residents' admission agreements sampled evidence residents' and facility representative sign off. The admission agreement includes all contractual requirements. Residents' files sampled demonstrate all needs assessments are completed for either rest home or hospital levels of care.  The facility manager interview confirms access and entry processes are followed. There is a facility information pack available for resident and their family. The resident information pack was sighted and contains all relevant information.   Interviews with eight of eight residents (three hospital and five rest home) and six of six family members (three rest home and three hospital) confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.   The district health board contract requirements are met. |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems to decline resident entry to the service are documented. The scope of the service provided by the organization is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the facility manager. The facility manager states residents will be declined entry if not within the scope of the service or if a bed is not available at the time. The facility manager states residents will be referred back to the referring agency. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the resident files sampled, there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident and/or family input, according to specified timeframes and the service is coordinated to promote continuity of service delivery. Seven of seven clinical staff (four registered nurses (RN) and three care givers) interviews confirm residents and/or family members are involved in all stages of service provision.  Eight of eight residents (five rest home and three hospital) interviews confirm their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews. Eight of eight residents' files (four rest home and four hospital) sampled demonstrate the care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.  Family communication sheets are maintained, sighted in all eight residents' files reviewed.  The auditor evidenced verbal briefing from am to pm shift. General practitioner (GP) interview was conducted and confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff. Staff competency assessments are current.  The district health board contract requirements are met.  Tracer Methodology Hospital. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology Rest Home  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' needs, outcomes and goals are identified via the assessment process and are recorded. The organisation has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment.  Eight of eight residents (five rest home and three hospital) interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care.  Resident files evidence risk assessments are conducted on admission and reviewed along with the resident long term care plan at six monthly intervals or when resident's condition alters. The district health board contract requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents' files sampled evidence residents' care plans are individualised and up-to-date. Residents’ goals are recorded and reviewed at regular intervals, at least six monthly or as needs change. Residents have input into their care planning and review, confirmed at all eight resident interviews.  Seven of seven clinical staff interviewed confirm that care plans are accurate and up to date.  Residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by the staff is current, the risk assessment findings are recorded on the care plans and there is evidence of discussions and sign off by residents and family members.  The facility ensures access to regular GP care, confirmed at GP interview. Residents’ care plan audit was conducted in March 2014, with 98% compliance. The district health board contract requirements are met. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documentation and observations made of the provision of services and/or interventions demonstrate that consultation and liaison is occurring with other services.  Residents' files sampled evidence the care plans record appropriate interventions based on assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the Service Agreement. Eight of eight residents (five rest home and three hospital) and six of six family (three rest home and three hospital) interviewed confirm their and their relatives current care and treatments they are receiving meet their needs. Family communication sheets record family communications, sighted in all residents' files sampled.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Interview with diversional therapist (DT) confirms there are two DTs employed at the facility, one for rest home and one for hospital. There are two activities programmes, one for the rest home and one for the hospital residents, sighted. The DT confirms the activities programme meets the needs of the service group and the service has appropriate equipment. The DTs are employed for total of 36 hours per week. Activities attendance records are maintained and are sighted.  Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned / spontaneous activities including festive occasions and celebrations.  Resident’s two monthly meetings are sighted for January to April 2014. There are separate resident meetings for rest home and hospital residents.  Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being.  Eight of eight residents and six of six family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities. Resident and family survey were conducted in February 2014.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes.  Evaluation are conducted by the RN with input from the resident, family, care givers, diversional therapist and GPs.  Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at six of six family interviews (three rest home and three hospital).  Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed.  Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.  Residents’ files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. Residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.  The district health board contract requirements are met. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident’s files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files where this is required.  The district health board contract requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The medication area in the facility evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs.  There is one controlled drug storage in the facility and this is secure. The controlled drug register is maintained and evidences weekly checks and six monthly physical stocktakes. Medication fridge temperatures are conducted and recorded.  Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).  Lunch time medication rounds were observed in rest home and hospital and evidence staff are knowledgeable about the medicine administered and sign off, as the dose is administered. There are 13 staff competent to administer medicines (10 RNs and three enrolled nurses). All staff authorised to administer medicines have current medication competencies. Additional staff competencies are conducted and these include; insulin administration; oxygen administration; nebuliser use. Staff education in medicine management was conducted by pharmacy staff in July 2013 and March 2014. Staff attendance is recorded. Sixteen medicine charts were sampled (eight rest home and eight hospital). All 16 charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.  There are four residents at the facility who self-administer medicines. There is recorded evidence of residents' competency assessments to self-administer medicines, completion of residents' signing sheets and safe storage of medicines. Interview with two residents who self-administers medicines was conducted and evidences the residents are competent and aware of the responsibilities with self-administration of medicines.  Sighted medication audit results for March 2014 with 100% compliance. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Food service policies and procedures are appropriate to the service setting with a new seasonal, dietitian approved, four weekly menu being introduced six monthly.  The kitchen staff are aware of residents individual dietary needs, confirmed at interview with the cook. Residents' dietary requirements are identified, documented and reviewed on a regular basis. There are current copies of residents' dietary profiles in the kitchen. Kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook.  Food safety training for kitchen staff have been conducted. Staff in-service training in nutritional requirements was conducted in August 2013 by a dietitian,  Residents' files sampled demonstrate monthly monitoring of individual resident's weight. Resident's nutritional needs and interventions are identified and documented on care plans.  Residents interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.  Food temperatures are recorded, sighted. Fridge and freezer temperatures are recorded and sighted. All decanted food is dated with expiratory dates recorded on containers. Food service audit was conducted in February 2014 with 100% compliance. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in December 2013. Two monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes.   Sluice facilities are available for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in the sluice room, laundry and cleaners’ room.   Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Alterations have been undertaken to the building since the last audit that includes redeveloping an existing area with seven bedrooms that were used by rest home residents, into bedrooms that can be used by either rest home or hospital residents. The redevelopment of this area also includes building an additional six bedrooms that can be used for either rest home or hospital level services as required. All of these bedrooms are large, single and have full ensuite facilities. A large new lounge and hair dressers room are also created as part of this rebuilding project.  Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.   A maintenance person is employed for nine hours a week and is interviewed during this audit. During interview the maintenance person confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance reports for medical equipment. A current Building Warrant of Fitness is displayed that expires 22 June 2014.  A visual Inspection of the facility provides evidence of safe storage of medical equipment, and the building, plant and equipment is maintained to a high standard. During interview the FM, quality manager and directors advise that there is an ongoing refurbishment programme in place that includes upgrading and enlarging the remaining rest home bedrooms to bring up to a standard that will enable them to be used by either rest home or hospital level residents. There is extensive evidence of the ongoing refurbishment programme that has been in place for the past few years evident during visual inspection.   Corridors are wide enough in all of the redeveloped areas to allow residents to pass each other safely. There is one area where the corridors are narrow but residents are observed passing each other safely. Safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (e.g., safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).   Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This was confirmed during interview of staff and review of staff education records. Care staff interviewed confirm they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.  Residents interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.   The district health board contract requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| With one exception, all bedrooms provide single accommodation and the majority have full ensuite facilities. There are an adequate number of toilet and shower facilities available throughout the facility.   Visual inspection provides evidence that toilet; shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).  All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and washbasin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence. |

##### **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:** |
| Visual inspection provides evidence that all of the redeveloped bedrooms are large and adequate personal space is provided to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents. Redeveloped bedrooms have double leaf doors that allow for easy access for mobility aids. The smaller older rest home bedrooms that are still to be redeveloped as part of the ongoing redevelopment plan have been closed off and are not being used at present.   Resident’s bedrooms are personalised to varying degrees. |

##### **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:** |
| Visual inspection provides evidence that adequate access is provided to lounges (three), dining rooms (two), sunroom and a recreation room. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |

##### **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:** |
| Alterations have been made to the laundry to improve the dirty – clean flow. A new large commercial dryer has been purchased and installed since the last audit.  Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons. All linen is washed on site in the laundry and there is adequate dirty / clean flow. A laundry worker is interviewed and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.  Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed. A cleaner is interviewed and describes the management of cleaning processes including the use of personal protective equipment. Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas. Residents interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of completed family and resident satisfaction surveys.  The district health board contract requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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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:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.  A New Zealand Fire Service (NZFS) letter dated 25 February 1999 is sighted advising the fire evacuation scheme has been approved. A letter from NZFS dated 08 July 2011 is also reviewed advising that following the building alterations undertaken to add further fire cells as part of building alterations that the scheme approved in February 1999 is current. There was a false alarm on 26 April 2014 resulting in a trial evacuation. Prior to this fire safety education and a trial evacuation was held on 28 November 2013.   Registered nurses and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training.   Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Emergency management training was last provided on 17 April 2014.  Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.   A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.   A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.   There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner. This is also confirmed during review of completed resident satisfaction surveys.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection provides evidence that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents interviewed confirm the facilities are maintained at an appropriate temperature.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place to ensure the use of restraint is actively minimised and the use of least restrictive practices are encouraged where required.  Restraint Minimisation and Safe Practice (RMSP) policy definitions of enablers and restraint align with the NZS 8134.2 Standard.  The service has an overarching risk and quality management system that demonstrates compliance with the Standard. There are 12 residents using restraint and four residents using enablers. Staff interviews and staff records evidence guidance has been given on RMSP, enabler usage and prevention and/or de-escalation techniques.  Staff education programme on RMSP /Enabler and challenging behaviour training was conducted in April 2014.  Restraint audit was conducted in March 2014 with 100% compliance. Restraint competencies for all clinical staff are current. |

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

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

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

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

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has processes in place for determining restraint approval and processes. Restraint is used only after all less restrictive interventions have been attempted and found to be inadequate. The role of the restraint co-ordinator is delegated to the facility manager. Interview with the restraint co-ordinator was conducted. Sighted position description of the restraint coordinator.  Staff interviews confirm responsibilities are clearly identified and known. Residents' files sampled evidence there is a recorded input into the restraint approval processes from residents and /or family.  Restraint is discussed at monthly quality improvement meetings.  RMSP policy/procedures define approved restraints and alternatives to restraint. Policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement.  The orientation / induction programme includes overview of RMSP policies/procedures.  Staff education programme includes on-going RMSP training. The district health board contract requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems are in place to ensure rigorous assessment of residents is undertaken prior to restraint usage being implemented.  Residents' files sampled demonstrate restraint assessment and risk processes are being followed.  Policies relate to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement. Residents' files where restraint is used evidence restraint assessment risks are documented and evaluated on a regular basis and include resident and/or family input.  Multidisciplinary reviews evidence restraint processes are reviewed.  The district health board contract requirement is met. |

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

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

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

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

Services use restraint safely

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Appropriate systems are in place to ensure the service is using restraint safely.  Restraint policies and procedures identify risk processes to be followed when a resident is being restrained.  The quality improvement meetings conducted monthly, include a review of restraint usage. Residents' files sampled demonstrate appropriate alternative interventions are implemented and de-escalation attempted prior to initiating restraint, this is completed by RNs. Restraint consent by resident and/or family are current. There are current restraint reviews in the files sampled.  A restraint register is established and records sufficient information to provide an auditable record of restraint use. There are 12 residents utilising restraint and four residents requesting the use of enablers.  The district health board contract requirement is met. |

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint evaluation processes are documented in policy. Policies relating to strategies to minimise use of restraint and management of challenging behaviour in accordance with the requirements of the Service Agreement are documented. Residents' files evidence that each episode of restraint is being evaluated based on the risk of the restraint being used and residents' care plan evaluations and multidisciplinary meetings are current.  The district health board contract requirement is met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Quality review of restraint and enabler use was last conducted in April 2014, sighted. The restraint monitoring and quality review occurs monthly at facility meetings. Meeting minutes evidence restraint evaluation. The RMSP policies and procedures include monitoring and quality review processes.  The district health board contract requirement is met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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 (IC) policy meets the needs of the organisation and provides information and resources to inform the staff on infection prevention and control, confirmed at staff interviews.  The infection control co-ordinator (ICC) is appointed to oversee the IC programme. There is an IC co-ordinator’s job description. There is documented evidence of regular reports on infection related issues by regular reporting systems.  The IC programme is reviewed annually; last review was conducted in April 2014.  The district health board contract requirement is met. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme meets the needs of the organisation and provides information and resources to inform and guide staff.  The IC co-ordinator / RN, has been in this position for three years. The IC co-ordinator has access to relevant and current information which is appropriate to the size and complexity of the organization, including but not limited to; IC manuals, internet, access to experts (DHB and Lab), and on-going in-service education. The IC co-ordinator has attended IC conference in 2013 and external education related to IC. The district health board contract requirement is met. |

##### **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:** |
| Policies and procedures on the prevention and control of infection include written material that is relevant to the organisation and reflects current accepted good practice and relevant legislative requirements. Policies and procedures are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interview.  The district health board contract requirements are met. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service provider's documentation evidences that infection control education is provided to all staff, as part of their initial orientation and is provided as part of the on-going in-service education programme.  Staff education was provided in February 2013 by an Infection Control nurse specialist from the DHB. All education sessions have evidence of staff attendance and content of the presentations. The facility manager states IC education is planned for May 2014 and this was sighted on the in-service planner. The district health board contract requirement is met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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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:** |
| The IC programme / policy details surveillance processes at a level of detail relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained.  Numbers of infections are collated at the end of each month and reported as a clinical indicator to management and to staff at meetings. Care staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RN's, and daily handovers. Infection control audit was conducted in June 2013 with 100% compliance and in December 2013 with 96.6% compliance and corrective actions have been addressed. The facility manager and the ICC state there has not been a norovirus outbreak at the facility. |

##### **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.)* |