# Social Service Council of the Diocese of Christchurch - Fitzgerald

## Current Status: 13 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

Fitzgerald Complex is certified to provide rest home, hospital and dementia care for up to 87 residents. On the day of the audit there were 30 residents at rest home level care, 30 residents at hospital level care and 16 residents receiving dementia care. The service is part of the Anglican Living organisation managed by a manager who is a registered nurse and well experienced. She is supported by a unit manager who is an experienced registered nurse in each unit. Family and residents interviewed all spoke positively about the care and support provided.

This audit identified improvements required by the service in the following areas; turning charts, neurological observations, wound documentation, aspects of medication management and including all infections in surveillance data.

## Audit Summary as at 13 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 |

| Indicator | Description | Definition |
|---|---|---|
| | 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 13 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 13 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 13 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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 13 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 13 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 13 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. | | Some standards applicable to this service partially attained and of low risk |

## Audit Results as at 13 May 2014

**Consumer Rights**

Fitzgerald Complex's mission is to provide quality of life in a Christian family environment that works in partnership to encourage independence and well- being. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

**Organisational Management**

Fitzgerald Complex has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health safety programme that includes hazard management.

Quality information is reported to monthly staff meetings and monthly quality/health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings (hospital residents) and two monthly meetings (rest home residents) and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Fitzgerald has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

**Continuum of Service Delivery**

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people

including residents and where appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. Communication with family is well documented. There are improvements required around turning charts, neurological observations and wound documentation.

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.

Policies and procedures around medicine management detail service provider's responsibilities. Registered nurses and senior health care assistants are responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are four residents who are self-administering medicines. There are improvements required around administration documentation, as required medication prescribing, weekly controlled drug checks and eye drops.

The service has transfer and discharge procedures. The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

**Safe and Appropriate Environment**

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is taken off site. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

**Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are two restraints one resident) and one enabler in place. Any use of restraint or enablers is reviewed monthly for each individual as part of the restraint and enabler register review, at the Quality/ Health and Safety meeting, and as part of the care plan and multi-disciplinary reviews at least six monthly. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

**Infection Prevention and Control**

The infection control coordinator is a registered nurse who has been employed at the service for three years. The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided bi-annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. There is an improvement required in infection surveillance.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## Introduction

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

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

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

## Audit Report

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|---|---|
| **Legal entity name:** | Social Service Council of the Diocese of Christchurch |
| **Certificate name:** | Social Service Council of the Diocese of Christchurch - Fitzgerald |

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

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| **Types of audit:** | Certification Audit |
| **Premises audited:** | Fitzgerald Retirement Complex |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | **Start date:** 13 May 2014 **End date:** 14 May 2014 |

| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 76 |

## Audit Team

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|---|---|---|---|---|---|
| **Lead Auditor** | XXXXX | **Hours on site** | 14 | **Hours off site** | 7 |
| **Other Auditors** | XXXXX | **Total hours on site** | 14 | **Total hours off site** | 7 |
| **Technical Experts** | | **Total hours on site** | | **Total hours off site** | |
| **Consumer Auditors** | | **Total hours on site** | | **Total hours off site** | |
| **Peer Reviewer** | XXXXX | | | **Hours** | 2 |

## Sample Totals

| | | | | | |
|---|---|---|---|---|---|
| Total audit hours on site | 28 | Total audit hours off site | 16 | Total audit hours | 44 |

| | | | | | |
|---|---|---|---|---|---|
| Number of residents interviewed | 9 | Number of staff interviewed | 17 | Number of managers interviewed | 3 |
| Number of residents' records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 87 | Number of relatives interviewed | 10 |
| Number of residents' records reviewed using tracer methodology | 3 | | | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

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

Dated Monday, 9 June 2014

# Executive Summary of Audit

| General Overview |
| --- |
| Fitzgerald Complex is certified to provide rest home, hospital and dementia care for up to 87 residents. On the day of the audit there were 30 residents at rest home level care, 30 residents at hospital level care and 16 residents receiving dementia care. The service is part of the Anglican Living organisation managed by a manager who is a registered nurse and well experienced. She is supported by a unit manager who is an experienced registered nurse in each unit. Family and residents interviewed all spoke positively about the care and support provided.<br>This audit identified improvements required by the service in the following areas; turning charts, neurological observations, wound documentation, aspects of medication management and including all infections in surveillance data. |

| Outcome 1.1: Consumer Rights |
| --- |
| Fitzgerald Complex's mission is to provide quality of life in a Christian family environment that works in partnership to encourage independence and well-being. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. |

| Outcome 1.2: Organisational Management |
| --- |
| Fitzgerald Complex has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health safety programme that includes hazard management.<br>Quality information is reported to monthly staff meetings and monthly quality/health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings (hospital residents) and two monthly meetings (rest home residents) and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Fitzgerald has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. |

| Outcome 1.3: Continuum of Service Delivery |
| --- |
| Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where |

appropriate family / Whanau or Enduring Power of Attorney. A registered nurse assessment, including a variety of risk assessments are completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans. Communication with family is well documented. There are improvements required around turning charts, neurological observations and wound documentation.
Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly.
Policies and procedures around medicine management detail service provider's responsibilities. Registered nurses and senior health care assistants are responsible for medicine management have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are four residents who are self-administering medicines. There are improvements required around administration documentation, as required medication prescribing, weekly controlled drug checks and eye drops.
The service has transfer and discharge procedures. The staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

**Outcome 1.4: Safe and Appropriate Environment**

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is taken off site. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are two restraints (one resident) and one enabler in place. Any use of restraint or enablers is reviewed monthly for each individual as part of the restraint and enabler register review, at the Quality/ Health and Safety meeting, and as part of the care plan and multi-disciplinary reviews at least six monthly. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

**Outcome 3: Infection Prevention and Control**

The infection control coordinator is a registered nurse who has been employed at the service for three years. The service has infection control policies and

an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided bi-annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. There is an improvement required in infection surveillance.

## Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|---|---|---|---|---|---|---|---|
| **Standards** | 0 | 47 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 2 | 2 | 0 | 0 |

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

## Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i) One resident (link 1.3.3) requires two hourly turns. The turning chart documentation indicates these are not occurring. The sample was increased to include two more two hourly turning charts and both also indicate that two hourly | (i)Ensure two hourly turns occur when indicated. (ii) Ensure wounds are reviewed within stated timeframes. (iii) Ensure each wound has an individual assessment, plan and reviews. (iv) Ensure neuro obs are completed when a resident has a knock | 90 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| | | | | turns have not been documented as occurring. (ii) Nine of the 15 wounds including one pressure area have not been reviewed within the stated timeframe. (iii) Three residents have more than one wound documented on the same assessment, plan and review making it difficult to differentiate between the wounds. (iv) Three incident forms sighted for residents who had experienced a knock to the head did not have neuro obs completed. | to the head. | |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i) Weekly controlled drug stocktakes have not occurred regularly in the hospital. (ii) In the rest home there are two open eye drops which are in use but have expired and in the hospital there is one eye drops in use that has expired and another that has not been dated when opened. (iii) Seven of 18 medication administration signing | (i)Ensure weekly controlled drug stocktakes occur. (ii) Ensure all eye drops are dated when opened and that eye drops are discarded when they expire. (iii) Ensure medication signing charts identify the medication is administered as prescribed. (iv) Ensure that PRN medications document an indication for use. | 30 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|---|---|---|---|---|---|---|
| | | | | sheets have regular medications that have not been signed as administered. (iv) Seven of 18 medication charts had PRN medications charted with no indication for use. | | |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Three of the four residents who self-administer medications have not had their competency assessment reviewed in the last three months. | Ensure residents who are self-administering medicines have a competency assessment review every three months. | 30 |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | | | |
| HDS(IPC)S.2008 | Criterion 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. | PA Low | Only infections that are treated are included in the surveillance data. | Ensure all infections are included in the surveillance data | 90 |

# Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br>Policies and procedures that adhere with the requirements of the Code are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training. Interviews with five registered nurses (RNs) (three unit managers and two hospital), and eight healthcare assistants (four rest home, two hospital and two dementia) showed an understanding of the key principles of the code of rights. Resident rights training was provided in February and April 2014 as part of the staff training workshop days scheduled two monthly in 2014. |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>There is a welcome information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family/whanau and, as appropriate, their legal representative. On-going opportunities occur via regular contact with family/whanau.<br>Advocacy pamphlets are clearly displayed on the notice board. Advocacy is brought to the attention of residents and families at admission and via resident and relatives meetings and the information pack. Interpreter services are available and information is clearly displayed. Interpreter services are documented in the admission agreement.<br>Interviews with nine residents (six rest home and three hospital), and 10 family/whanau members (one rest home, six hospital and three dementia), all confirmed that information has been provided around advocacy. Residents surveys in February 2014 shows evidence that 100% of residents that responded indicate awareness of the complaints process and how to lodge a complaint or concern.<br>D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, advocacy, interpreter services and H&D Commission information. Admission agreements signed by the residents and/or family also provide information. The code of rights poster is available on the walls around the service. English and Maori leaflets are available and large print leaflets are available when required. |

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

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

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

### Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)
Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

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

## Standard 1.1.3: 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:**<br><br>The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident rooms. Five RNs (three unit mangers and two hospital), and eight healthcare assistants (four rest home, two hospital and two dementia) interviewed described ensuring privacy by knocking before entering private areas. This was observed during audit.<br>Values and beliefs information and resident preferences are gathered on admission with family/whanau involvement and are integrated into the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with all eight healthcare assistants identified how they get to know resident values, beliefs and cultural differences.<br>Interviews with nine residents (six rest home and three hospital), confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with eight health care assistants described providing choice including what to wear, food choices, how often they want to shower, what activities were on for the day and whether they wanted to be participate in activities.<br>Discussions with nine of nine residents (six rest homes, three hospital) and 10 of 10 family/whanau members (one rest home, six hospital and three dementia) were overall positive about the care provided. Resident and relative survey in February 2014 evidenced positive feedback regarding privacy dignity and respect.<br>D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.<br>D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.<br>D4.1a: Three of three families/whanau from the dementia unit state that their family member was welcomed into the unit and personal items and pictures were put up to assist them to orientate to their new environment. |

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

### Criterion 1.1.3.6 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.1.3.7 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.1.4: 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:**<br><br>There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Maori tikanga best practice guideline information is clearly visible in the hospital/rest home and dementia unit. Staff receive cultural training. Training occurred in April 2014. Cultural needs and support is identified in care plans. There is an established Maori health plan and individual care plans include the cultural needs of residents. Currently there are no residents in the service who identify as Maori.<br>A3.2: There is a Maori health plan, which includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).<br>D20.1i: The service has developed a link with local Maori services such as Nga Hau E Wha National Marae.<br>The policies for Māori identify the importance of family/whānau. Interviews with, five RNs (three unit managers and two hospital) eight healthcare assistants (four rest home, two hospital and two dementia) and the manager (RN) discussed the importance of family involvement. Discussion with 10 family/whanau members (one rest home, six hospital and three dementia), confirm that they are regularly involved. |

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

### Criterion 1.1.4.3 (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:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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

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

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

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

| **Attainment and Risk:** FA |
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| **Evidence:**<br>The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. The service has a part time chaplain who assists at church services on site. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans.<br>D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture resident's information regarding culture and beliefs.<br>D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs. |

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

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

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

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

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

ARHSS D16.5e

| **Attainment and Risk:** FA |
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| **Evidence:**<br>Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. |

Five RNs (three unit managers and two hospital), and eight healthcare assistants (four rest home, two hospital and two dementia) interviewed were able to describe appropriate boundaries between staff and residents and their families.
Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

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

## Standard 1.1.8: 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:**<br><br>The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A formal quality improvement programme has been developed which includes identification through to resolution. Care planning is holistic and integrated and included a six monthly multi-disciplinary review meeting. Educational training plans are in place. Staff development occurs by way of education and in-service training. ACE (Aged Care Education) and in-service training is planned. The manager and the quality and education coordinator attend training sessions appropriate for their positions.<br>A2.2: Services are provided at Fitzgerald complex that adhere to the Health and Disability Sector Standards. There is an implemented quality improvement programmes that includes performance monitoring.<br>D1.3: All approved service standards are adhered to.<br>D17.7c; There are implemented competencies for caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions |

### Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)
The service provides an environment that encourages good practice, which should include evidence-based practice.

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

## Standard 1.1.9: 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:**<br><br>Accident, incidents, complaints and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any adverse event that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.<br>Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. All 12 incident forms reviewed identified that family were notified. An interpreter policy is in place. Interpreter services are available and information is clearly displayed. Interpreter services are documented in the resident's admission agreement. At present there are no residents where English is their second language. There are staff that are able to assist with interpreting for care delivery (e.g., Maori, Samoan). Residents surveys in February 2014 provides evidence that of those that responded 100% report that staff maintain good levels of communication.<br>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.<br>D16.1b.ii: Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.<br>D16.4b: Ten of 10 families/whanau (one rest home, six hospital and three dementia) report they are kept informed when their family member's health status changes. |

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

### Criterion 1.1.9.4 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.1.10: 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:**<br><br>Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for nine of nine files sampled (three from the rest home, three from the dementia unit and three from the hospital). Nine files were reviewed and found to have valid consents. It was stated by the registered nurses that family involvement occurs with the consent of the resident. Other forms of written consent included consent to share information, consent for photographs and consent for transportation. These are included in the admission agreement. A review of nine files found all consents were present and signed by the resident or their enduring power of attorney (EPOA). EPOA documents are kept on the resident's file. Nine residents interviewed (three from the hospital and six from the rest home) confirm that they are given good information to be able to make informed choices. Eight health care assistants, five registered nurses including two unit managers and the manager interviewed conform information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.<br>D13.1 There were nine of nine admission agreements sighted.<br>D3.1.d Discussion with 10 families (one from the rest home, three from the dementia unit and six from the hospital) identified that the service actively involves them in decisions that affect their relative's lives. |

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

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

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

### Criterion 1.1.10.4 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.1.10.7 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.1.11: 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:**<br><br>Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file.<br>D4.1d: Discussion with 10 family members (one rest home, six hospital and three dementia), identified that the service provides opportunities for the family/EPOA to be involved in decisions.<br>D4.1e: The resident file includes information on resident's family/whanau and chosen social networks. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br><br>The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations. |

D3.1h: Discussion with all 10 family determined that they are encouraged to be involved with the service and care and are free to visit anytime.
D3.1.e: Discussion with all staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community and external groups such as church.

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

### Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)
Consumers are supported to access services within the community when appropriate.

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

## Standard 1.1.13: 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

| **Attainment and Risk:** FA |
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| **Evidence:**<br><br>A complaints process is in place. The complaints procedure is provided to residents and relatives at entry both in writing and verbally (evidenced in interviews with the manager, unit managers and registered nurses). Documentation relating to complaints is held in the complaints folder, which serves as the complaints register. Nine complaints were lodged in 2014. Four complaints were selected for review. In each instance, appropriate follow-up action had been taken and was documented. Discussions with nine residents (four three, six rest home) and 10 families/whanau (six hospital, one rest home and three dementia) confirm they are provided with information on complaints and understand the complaints process.<br>D13.3h: A complaints procedure is provided to residents with the information pack at entry.<br>E4.1biii: .There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:<br>1. Minimising restraint.<br>2. Behaviour management.<br>3. Complaint policy. |

### 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.

| **Attainment and Risk:** FA |
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| **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 1.1.13.3 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# Outcome 1.2: Organisational Management

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

## Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)
The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br>The strategic plan for the facility (1 July 2013 - 30 June 2014) includes a vision, a mission statement and core values. The organisations mission is "To enhance quality of life within a Christian family environment". Fitzgerald complex is working towards adapting Eden philosophies. The core values are dignity, respect, compassion and wellbeing. Fitzgerald complex is part of Anglican Living Aged Care organisation responsible to the Anglican Care Trust Board. There is a director who has a bachelor of arts in social sciences and post graduate diploma in management. She has considerable experience in aged care. The director reports quarterly to the Anglican Living Committee. Fitzgerald Complex provides care for up to 87 residents across rest home, hospital and dementia service levels. There are 76 residents living at the facility (30 rest home, 30 hospital and 16 dementia). Fitzgerald Complex has a manager who is a registered nurse with a current practising certificate. She has been the manager at Fitzgerald Complex since Feb. 2013. Her experience includes four years as a charge nurse at Canterbury District Health Board, two years as an integrated service manager and a manager of a dementia facility in New Zealand. She works forty hours per week. The manager's job description documents her role and responsibilities. She has attended a manager's seminar NZACA EPOA workshop in 2013, an aging spirituality conference in September 2013 and has maintained professional nursing development. She has a post graduate diploma in health sciences endorsed in nursing from Otago university and has a post graduate diploma in management from Exeter (UK). She is currently completing her dissertation for post graduate nursing education. She is supported by a unit manager who is an experienced registered nurse in each unit.<br>ARC, D17.3di: The manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility. |

ARC E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

### Criterion 1.2.1.3 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.2.2: 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:**<br>During a temporary absence, the project manager (RN) for the organisation undertakes the role of manager. She has extensive aged care experience. The quality and education coordinator (RN) and the director of Anglican Living also supports the project manager as required. Both have extensive experience in aged care nursing and management.<br>D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Fitzgerald Complex has quality and risk management programmes in place. The programme is reviewed annually and includes quality objectives and key strategies Interviews with staff and a review of meeting minutes demonstrate a culture of continuous quality improvements. The service has policies and procedures and associated implementation systems to provide a level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.
Policies and procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. They are reviewed a minimum of two-yearly with the quality and education coordinator reporting more frequent reviews where changes have occurred. When there is a change in a policy or procedure the manager reports she discusses policy updates in staff meetings, confirmed by review of staff meeting minutes and interviews with eight health care assistants (four rest home, two hospital and two dementia), five registered nurses (three unit managers and two RNs).
Document control includes; a) policy development, b) approval of policies, c) policy implementation, d) developing a new policy, and e) reviewing an existing policy.

There is a quality and risk management process being implemented at Fitzgerald Complex. The monitoring programme includes (but is not limited to); restraint compliance, building compliance, cleaning, informed consent, fire, food service, individual care plans, infection control and hand washing, laundry services, medication, privacy of information, resident admission, resident care, activities, resident rights, safety, resident satisfaction, staff education disturbing behaviour management. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. A quality improvement system has been introduced whereby any staff member may initiate a quality improvement request by completing a quality improvement request form, which includes the details of the quality improvement, the follow-up actions undertaken by management, and the outcome. Initiatives are discussed in staff meetings, and in the quality meetings. A quality improvement register has been developed to ensure that quality initiatives are recorded and signed off on completion. A recent quality improvement has been the introduction of a breakfast buffet bar for rest home residents with positive feedback.

Monthly 'quality improvement team' meetings are in place, which also includes health and safety (meeting minutes sighted). Information from these meetings is carried on to the monthly staff meetings and a copy is available in the staff room (meeting minutes sighted). Graphs of data analysis including incidents and infections are also available in the staff room.

Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Accident/incidents/near miss reports are completed and broken down and reported on at staff meetings and quality/health and safety meetings (meeting minutes sighted). Hazard identification and hazard control is up to date with a hazard register in place.

D19.3: There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. A health and safety officer is appointed.
D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and managing this population appropriately.

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

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

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

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

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

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

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

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

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

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

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

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

### Criterion 1.2.3.6 (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:** |

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

### Criterion 1.2.3.7 (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:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.2.3.8 (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:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.2.3.9 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.2.4: 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:**<br><br>The service collects incident and accident data The incident/accident form provides an account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence.<br>D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required (link 1.3.6.1 re: neurological observations).<br><br>Twelve incident forms were reviewed across the service and all demonstrated clinical follow-up by a registered nurse. Incidents and accidents are reviewed and followed up by the manager (RN). There is also evidence of an incident form being documented and followed up for each event (evidenced in follow-up of 12 of 12 adverse events).<br>D19.3c Fitzgerald Complex has a reportable event policy. Policy identifies the events that need to be reported, by whom and the process to follow. Discussions with the manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications. |

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

### Criterion 1.2.4.3 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Evidence was sighted of current annual practising certificates for two enrolled nurses' and15 registered nurses. Three of the registered nurses are unit managers. Practising certificates are also available on-site for the podiatrist, pharmacy and general practitioner. Website links to the professional bodies of all health professionals are in place.
Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files were randomly selected for review. Ten of 10 staff files reviewed includes up-to-date performance appraisals.
The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New caregivers are buddied with an experienced caregiver during their induction programme. Completed orientation checklists were available for sighting in 10 of 10 staff files sampled. Staff interviewed eight healthcare assistants (four rest home, two hospital and two dementia), and five registered nurses (three unit managers and two RNs) are able to describe the orientation process and report that new staff are adequately orientated to the service. The manager follows up to ensure orientation checklists are completed.

Discussions with staff and management confirm that an in-service training programme is in place. In-service training for 2013/2014 included (but not limited to): challenging behaviours (attendance = 29); fire and disaster training (attendance of 68); code of rights /informed consent (attendance = 21); spirituality (attendance = 14); manual handling (attendance = 19); continence management (attendance = 17); infection control food handling (attendance = 36). The service also runs training workshops days where several educational topics are covered. These have been held in February and April 2014. There is a 2014 education planner in place. Eight registered nurses and two enrolled nurses have current first aid certificates. Staff are also encouraged to attend external education confirmed by health care assistants that have attended "Walking in their Shoes" dementia training.
The cook and kitchen staff have completed food safety certificate. Food services are provided by an external contractor.

D17.7d: A competency programme is in place with evidence of annual medication competencies for the registered nurses, enrolled nurse and senior caregivers. Core competencies are also completed for all staff relating to fire and emergency plans.
E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.
E4.5e: Agency staff receives an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.
E4.5f: Sixteen of nineteen health care assistants who work in the dementia unit have completed the required dementia training through the ACE (aged care education). One health care assistant has one module to complete and two health care assistants have only been working in the dementia unit for six months and are currently completing the dementia ACE programme.

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

### Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

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

### Criterion 1.2.7.4 (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:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.2.7.5 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.2.8: 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:**<br>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All 10 families/whanau (six hospital, one rest home and three dementia) and nine residents (three hospital and six rest home) interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the unit managers or the manager will be on-call at all times, that at least one staff member on duty registered nurse (RN) will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The project manager (RN) for the organisation and quality and education coordinator (RN) covers the manager during absences and holidays. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents. |

A contractor physio attends the facility for 9.5 hours a week.

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

## Standard 1.2.9: 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:**<br><br>The resident records sampled at Fitzgerald Complex contain adequate and appropriate information relevant to the service. Residents entering the service have all relevant information recorded within 24 hours into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents records are kept in secure nurses stations accessible to staff. Support plans and notes are legible and where necessary signed (and dated) by the registered nurse and health care assistants.<br>There are policies that outline security of records.<br>D7.1: Entries are legible, dated and signed by the relevant caregiver, enrolled nurse or registered nurse including designation. Individual resident files demonstrate service integration with notes by allied health professional and the GP. |

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

### Criterion 1.2.9.7 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.2.9.9 (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:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.2.9.10 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Outcome 1.3: 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:** |
| Prior to entry to Fitzgerald Complex potential residents have a needs assessment, completed by the needs assessment and co-ordination service to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information |

pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.
E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:
1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.
D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract
D14.1 Exclusions from the service are included in the admission agreement.
D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
E3.1 Three resident files were reviewed from the dementia unit and all include a needs assessment as requiring specialist dementia care.

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

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

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

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

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

ARHSS D4.2

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

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

## Standard 1.3.3: 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:**<br><br>D16.2, 3, 4: The nine resident files reviewed (three from the rest home, three from the dementia unit and three from the hospital) identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of nine care plans evidenced evaluations completed at least six monthly. Three residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activities coordinators. Nine residents (six rest home and three hospital), interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records which were completed in all resident files sampled.<br><br>D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly where this is the case. More frequent GP review was evidenced as occurring on review of resident's files with acute conditions or where the GP has identified the need for more frequent reviews. The GP interviewed spoke highly of the service offered.<br>Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Nine files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents' health status and he believes the service provided meets resident's needs.<br><br>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.*

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

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

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

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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 1.3.3.3 (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:** |
| **Finding:** |
| **Corrective Action:** |

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

### Criterion 1.3.3.4 (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:** | |
| **Finding:** | |
| **Corrective Action:** | |
| **Timeframe (days):** | *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.3.4: 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

**Attainment and Risk:** FA

**Evidence:**

The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. Pain assessment was evidenced completed with on-going monitoring recorded for residents requiring administration of controlled medication as part of prescribed pain management plan. Ten family (one from the rest home, three from the dementia unit and six from the hospital) and nine residents interviewed (three from the hospital and six from the rest home) interviewed are very satisfied with the support provided.
ARC E4.2: Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.
E4, 2a Challenging behaviours assessments are completed.

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

## Standard 1.3.5: 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:**<br>The sample of files reviewed included;<br>Hospital: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*<br>Dementia: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*<br>Rest home: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*<br>A review of nine resident files identify the use of short term and long term care plans. These reflect variances in resident health status. All nine are current and include interventions relating to all identified areas of need. There is evidence of six monthly review which is signed by a registered nurse.<br>The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist.<br>E4.3 Three resident files reviewed from the dementia unit identified current abilities, level of independence and specific behavioural management strategies.<br>D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.<br>All nine resident files reviewed identified that family were involved. Family contact sheets located at the front of residents' files demonstrated communication with family/EPOA.<br>D16.3k: Short term care plans are in use for changes in health status. |

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Nine resident files were reviewed (three from the rest home, three from the dementia unit and three from the hospital). All identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of nine care plans evidenced evaluations completed at least six monthly. Three residents have not yet been at the service for six months. Activity assessments and the activities sections in care plans have been completed by the activity coordinators. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, health care assistants, and registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly or more medical review. The quality and education coordinator is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by health care assistants or registered nurses in progress notes at least daily in the dementia unit and rest home and each shift in the hospital (evidenced in all nine residents' progress notes sighted).

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

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for 15 residents with wounds including three pressure areas. Nine of the 15 wounds including one pressure area have not been reviewed within the stated timeframe. Three residents have more than one wound documented on the same assessment, plan and review making it difficult to differentiate between the wounds. These are areas requiring improvement.
The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.
Continence management in-services and wound management in-service have been provided.
During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

When a resident's condition alters, the registered nurse initiates a review and if required, arrange a GP visit or a specialist referral. The eight health care assistants, two registered nurses, three unit managers, the quality and education coordinator and the manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves

and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Nine residents interviewed (three from the hospital and six from the rest home) interviewed were complimentary of care received at the facility.
D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for 15 residents with wounds including three pressure areas. The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.
Continence management in-services and wound management in-service have been provided.
During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.

**Finding:**

(i) One resident (link 1.3.3) requires XXXXX. The XXXXX chart documentation indicates these are not occurring. (ii) Nine of the 15 wounds including XXXX have not been reviewed within the stated timeframe. (iii) Three residents have more than one wound documented on the same assessment, plan and review making it difficult to differentiate between the wounds. (iv) Three incident forms sighted for residents who had experienced a knock to the head did not have neurological observations completed.

**Corrective Action:**

(i)Ensure two hourly turns occur when indicated. (ii) Ensure wounds are reviewed within stated timeframes. (iii) Ensure each wound has an individual assessment, plan and reviews. (iv) Ensure neurological observations are completed when a resident has a knock to the head.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are five activities coordinators at Fitzgerald Complex who are responsible for the planning and delivery of the activities programme. There is a separate programme that runs over seven days in the rest home and dementia unit and over five days in the hospital. There is a diversional therapist who meets with the activities coordinators periodically and has oversight input into the dementia unit programme. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events.
The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.
Fitzgerald Complex has its own van for transportation. Residents interviewed described attending concerts, going shopping, lunches and picnics, and shopping. The

activities coordinators have a current first aid certificate.
In the dementia unit there is a cupboard that is open at all times where residents (and families if desired) can access pens and paper, board games, puzzles and cards at any time. There is also a resource cupboard where staff can access a variety of activities at any time and there is a document with suggestions for activities over the 24 hour period.
D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.

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

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

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

## Standard 1.3.8: 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:** |

There is at least a three monthly review by the medical practitioner.
D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six of nine care plans sampled. The other three residents have not yet been at the service for six months. There are short term care plans to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. One STCP reviewed evidenced transition into the long term care plan (link 1.3.3). Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. Health care assistants interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions which occur at the beginning of each shift.
ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission.

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

### Criterion 1.3.8.3 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

| **Attainment and Risk:** FA |
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| **Evidence:**<br><br>The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, speech language therapist, occupational therapist and wound care nurse.<br>D16.4c: The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.<br>D 20.1; Discussions with the registered nurses and clinical nurse leaders identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, nurse practitioner intern, occupational therapist and physiotherapist. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:**<br>There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.<br>Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:**<br>Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital, dementia unit and rest home. |

Controlled drugs are stored in a locked safe in the hospital and rest home and two medication competent persons must sign controlled drugs out. Weekly stocktakes have not occurred regularly in the hospital and this is an area requiring improvement. The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.
All open eye drops in the facility were sighted. In the rest home there are two open eye drops which are in use but have expired and in the hospital there is one eye drops in use that has expired and another that has not been dated when opened. This is an area requiring improvement.
Staff sign for the administration of medications on medication signing sheet. Seven of 18 medication administration signing sheets have regular medications that have not been signed as administered. Seven of 18 medication charts had PRN medications charted with no indication for use. These are areas requiring improvements. The medication folder includes a list of specimen signatures.
Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.
Education on medication management occurred in 2014. Registered nurses and health care assistants administer medicines. All have been assessed as competent.
There are appropriate policies around residents who self-administer. There are four residents in the rest home who self-administer medications and all have these stored safely. Three of the four residents who self-administer medications have not had their competency assessment reviewed in the last three months. This is an area requiring improvement.
D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in a locked treatment in the hospital, dementia unit and rest home. Controlled drugs are stored in a locked safe in the hospital and rest home and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly in the rest home. The service uses four weekly blister packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.
Staff sign for the administration of medications on medication signing sheet. Seven of 18 medication administration signing sheets have regular medications that have not been signed as administered. Seven of 18 medication charts had PRN medications charted with no indication for use. These are areas requiring improvements. The medication folder includes a list of specimen signatures.

**Finding:**

(i) Weekly controlled drug stocktakes have not occurred regularly in the hospital. (ii) In the rest home there are two open eye drops which are in use but have expired and in the hospital there is one eye drops in use that has expired and another that has not been dated when opened. (iii) Seven of 18 medication administration signing sheets have regular medications that have not been signed as administered. (iv) Seven of 18 medication charts had PRN medications charted with no indication for use.

**Corrective Action:**

(i)Ensure weekly controlled drug stocktakes occur. (ii) Ensure all eye drops are dated when opened and that eye drops are discarded when they expire. (iii) Ensure medication signing charts identify the medication is administered as prescribed. (iv) Ensure that PRN medications document an indication for use.

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

### Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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

### Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

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| **Attainment and Risk:** PA Low |
| **Evidence:**<br>There are appropriate policies around residents who self-administer. There are four residents in the rest home who self-administer medications and all have these stored safely. Three of the four residents who self-administer medications have not had their competency assessment reviewed in the last three months. |
| **Finding:**<br>Three of the four residents who self-administer medications have not had their competency assessment reviewed in the last three months. |
| **Corrective Action:**<br>Ensure residents who are self-administering medicines have a competency assessment review every three months. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.3.12.6 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.3.13: 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:**<br><br>Fitzgerald Complex externally contracts the cooking service and all food is cooked on site. There is a chef manager, two cooks and five kitchen hands. All have food safety training. Catering for another site owned by the organisation is also completed at the Fitzgerald site. The kitchen is in the rest home building and meals are transported by truck in hot boxes to the hospital and dementia unit where they are transferred to a bain marie prior to serving. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in August 2013.<br>A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily.<br><br>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the chef manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include pureed diets, soft diets, gluten free and vegetarian. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule which is signed by member of staff completing cleaning tasks.<br>E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.<br>D19.2 Staff have been trained in safe food handling. |

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

### Criterion 1.3.13.2 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.3.13.5 (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:** |
| **Corrective Action:** |
| **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:**<br>The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards.<br>Continence products are disposed of via a waste company who then converts them to compost. |

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

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

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

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

## Standard 1.4.2: 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:**<br><br>Reactive and preventative maintenance occurs.<br>The service is provided over two buildings on the same site with the rest home in one building and the hospital and dementia unit in the other building. Fire equipment is checked by an external provider. The facility holds a current warrant of fitness (which covers both buildings) which expires 1 April 2015. Electrical equipment is checked and this last occurred in May 2013. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.<br>Hoists are serviced annually and this last occurred in June 2013. Medical equipment was last calibrated in August 2013. |

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.
ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, seated and wheelchair scales heel protectors, lifting aids.
E3.3e: There are quiet, low stimulus areas that provide privacy when required.
E3.4.c: There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

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

### Criterion 1.4.2.4 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

### Criterion 1.4.2.6 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Standard 1.4.3: 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:**<br>The service has single rooms in the dementia unit and rest home and two double rooms and the remainder single in the hospital. The two double rooms currently have single occupancy. Fifteen resident rooms in the rest home and 14 in the hospital have full ensuite facilities. There are communal toilets and showers close to bedrooms. Toilets are located close to dining rooms and lounges for residents' use. A visitor's toilet is available in each area. Water temperatures are tested monthly by the maintenance person and records show they are within safe limits. |

### Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)
There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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

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| **Finding:** |
| **Corrective Action:** |
| **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:**<br>Observation on day of audit demonstrated walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with health care assistants. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists. |

### 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 manoeuvre with the assistance of their aid within their personal space/bed area.

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

## Standard 1.4.5: 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:**<br>There are several large lounges and dining areas in each unit. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.<br>E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| **Finding:** |
| **Corrective Action:** |
| **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:**<br>All laundry is contracted out and completed off site. Chemicals are stored in a locked room in each unit. There are two sluice rooms each in the rest home and hospital and one in the dementia unit. All chemicals are labelled with manufacturer's labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. |

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| Cleaning audit occurred in February 2014 and corrective actions were implemented following this. |

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

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

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

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

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

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

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

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

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

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br><br>Fire evacuation practice documentation sighted (12 & 13 September 2013). A contracted service provides checking of all facility equipment including fire equipment and electrical tagging. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence boxes situated in each area (hospital, rest home and dementia) are available (sighted). The staff confirmed that they have civil defence equipment including alternative cooking methods (gas supplied to the kitchen and barbeques) if required. Gas heaters are available if required. There is access to a generator if required. There is sufficient water stored to ensure for three litres per day for three days per resident.<br>The staffing level provided adequate numbers of staff to facilitate safe care to rest home, dementia and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate (RN). The NZ Fire Service approved the evacuation scheme on 12 February 1999 (hospital and dementia building) and 17 November 1997 (rest home building).<br>There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There are security checks two- three times nightly by an external contractor There is a registered nurse on site available to all residents 24 hours per day, seven days per week.<br>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |

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

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

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

### Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation plan.

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

### Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

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

### Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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

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

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

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

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

## Standard 1.4.8: 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

| | |
|---|---|
| **Attainment and Risk:** | FA |
| **Evidence:** | |
| The facility has heating in hallways, bedrooms and communal areas. The temperature can be adjusted to suit individual resident temperature preference. Rooms are well ventilated and windows provide natural light. Facility temperatures are monitored. Nine residents interviewed stated the temperature of the facility was comfortable. | |

### Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

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

### Criterion 1.4.8.2 (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:** |
| **Finding:** |
| **Corrective Action:** |
| **Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

# Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br><br>The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the manager (RN), quality and education coordinator (RN), five RNs (three unit managers and two hospital ), and eight healthcare assistants.<br>There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures and is reviewed annually.<br>The process of assessment and evaluation of enabler use is in place. Currently there are two restraints (one lap belt and one bedrails) for one resident and one enabler in place. On review of the two files (one enabler, one lap belt and one bedrail restraint). Included in the file is an assessment process that covers alternatives and least restrictive options. The enabler, lap belt and bedrail restraint is also linked to the resident's care plan.<br>A restraint register completed includes each restraint and is evaluated monthly.<br>There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings. There is a five year plan to replace all beds with low beds in the hospital area.<br>E4.4a The care plans reviewed focus on promotion of quality of life and minimise the need for restrictive practises through the management of challenging behaviour. |

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

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

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

# Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br>The restraint coordinator is a registered nurse and the hospital unit manager who has considerable experience in aged care and has been employed at the facility for one year. Assessment and approval process for a restraint intervention includes the RN, resident/or representative and medical practitioner. |

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

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

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

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

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In two files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family/whanau involvement and a specific consent for enabler / restraint form is used to document approval. These were sighted in the one restraint file and one enabler file reviewed. |

### 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.

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

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

Services use restraint safely

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

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The one file reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the one file reviewed. One file reviewed has a consent form detailing the reason for restraint and the restraint to be used. In the residents file reviewed, monitoring forms had been completed. Assessments are completed. A monthly evaluation of restraint is completed that reviews the restraint used. The service has a restraint and enablers register for the facility that is up dated each month. |

### 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.

| |
|---|
| **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:**<br><br>The service has documented evaluation of restraint every month. In the one restraint file reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.<br>Restraint practices are reviewed on a formal basis annually by the restraint approval group and monthly by the facility restraint co-ordinator at quality/health & safety meetings. Individual evaluation timeframes are determined by risk levels otherwise reviewed three monthly. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. |

### 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.

| |
|---|
| **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:** |
| **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:**<br>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed four monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator with family and GP. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly quality meetings. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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|---|
| **Attainment and Risk:** FA |
| **Evidence:**<br>The role of the infection control (IC) coordinator is held by one of the registered nurses who has been employed at the service for three years and has been the IC for two years. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The IC programme is appropriate for the |

size and complexity of the service. The programme is approved and reviewed annually by the coordinator, quality and education coordinator, management team and external expertise when required. IC is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register (link 3.5.7).
There is a job description for the IC coordinator including the role and responsibilities of the position. IC is part of the audit schedule and is undertaken three times a year.
There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.

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

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

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

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

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

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

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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 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:**<br>The registered nurse is the IC coordinator. IC matters are taken to all staff and quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. She has the responsible for reviewing the IC programme annually with the quality and education coordinator and management team. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:**<br>Fitzgerald Complex has infection control policies and an infection control manual, which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme is reviewed annually by the IC coordinator, quality and education coordinator and management team who access external specialist advice to do this.<br>D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections. |

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:**<br>The IC coordinator is a registered nurse who has undertaken specialist IC training including a Bug Control seminar and a polytechnic course. All new staff receive infection control education at orientation including hand washing and preventative measures. Bi-annual infection control education occurs. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained |

### 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:** |
| **Finding:** |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:**<br><br>The IC coordinator enters infections that are treated on to the infection register and carries out a monthly analysis of the data. This is an area that requires improvement as only infections requiring treatment are included. The analysis is reported to the monthly staff and quality meetings (minutes viewed). The resident's long term care plan included a section on infections which is analysed for individual trends. The IC coordinator and quality and education coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.<br>Internal audit of infection control is included in the annual programme and occurs yearly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. |

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

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

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

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

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

| |
|---|
| **Attainment and Risk:** PA Low |
| **Evidence:**<br>Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents |
| **Finding:**<br>Only infections that are treated are included in the surveillance data. |
| **Corrective Action:**<br>Ensure all infections are included in the surveillance data |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |