# Oceania Care Company Limited - Eldon Lodge

## Current Status: 5 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

Eldon Lodge Rest Home and Hospital (Eldon) provides residential care for up to 133 residents who require hospital, rest home and dementia level care. Occupancy on the day of the audit is at 116. The facility is operated by Oceania Care Company Limited. Staffing is stable with minimal turnover and staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.

There have been no changes to the building, staffing structure, management or systems since the last audit. Continuous improvements have been noted during this audit relating to all aspects of service delivery with the exception of the food service which has been identified as an area that requires some improvement.

## Audit Summary as at 5 May 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 5 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 5 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 5 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 low risk. |

### Safe and Appropriate Environment as at 5 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 5 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 5 May 2014

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

## Audit Results as at 5 May 2014

### Consumer Rights

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

During interview residents and family confirm that consent forms are provided to them prior to admission to ensure they have time for consultation and that they are fully informed. Time is provided if discussions and explanation is required.

The facility manager is responsible for the management of complaints and a complaints register is maintained. The residents can use the complaints forms, raise issues at the residents' meetings, or they can raise complaints directly with the facility manager, the clinical manager, or with any member of staff.

### Organisational Management

Oceania Care Company Limited is the governing body and is responsible for the service provided at Eldon. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Eldon including regular monthly reporting by the facility manager and the clinical manager to the Oceania head office. The facility is managed by a suitably qualified and experienced facility manager who is a registered nurse with extensive aged care experience. The facility manager is supported by a clinical manager who is a registered nurse and who is responsible for oversight of clinical care provided. The clinical manager is supported by four charge nurses, one for each of the four areas, who are senior registered nurses.

The Oceania Care Company Limited quality and risk management systems are in place at Eldon. There is extensive evidence available indicating that quality improvement data is being collected, collated, and comprehensively analysed to identify trends and improve service delivery. There is an internal audit programme in place and there is evidence that corrective action plans are developed, implemented and monitored to address any areas identified as requiring improvement. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms as well as on an electronic database that is able to be reviewed by personnel from Oceania’s support office.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. Inservice education is provided for staff on a daily basis and staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ‘Oceania Certificate in Residential Care’. A review of staff records provides evidence that human resources processes are being followed (eg, reference checking, criminal record vetting, and interview questionnaires are completed), orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two registered nurses and six health care assistants. The facility manager and/or the clinical manager are on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

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

### Continuum of Service Delivery

The service has policies and procedures to guide entry criteria, assessment and screening. The admission agreement defines the scope of service and access and entry processes are followed. The service has an admission pack available for residents who are new and for their family. The service has a system in place for informing people who are declined to the service. Residents receive timely, competent and appropriate services meeting their assessed needs. Residents are involved in assessments, care planning and review of care.

Risk assessments are completed on admission and recorded in care plans. Goals are identified by residents and service providers and reviewed at six monthly intervals or when needs change. Resident files sampled evidence the clinical interventions, treatment, support and care provided by the staff is current. GP records are current. The diversional therapists and the activities coordinator plan and implement the activities with a focus on the resident’s abilities, interests and needs. Residents in the dementia unit have 24 hour challenging behaviour management plans to guide the service as part of their assessments completed. Evaluation of person centred care plans are within required timeframes and reviewed. Family are notified of changes in resident's condition. Resident files reviewed show evidence of input from other services such as specialists. Multidisciplinary reviews are current. Transitions, exits, discharge and transfers are planned and coordinated by the RN’s or the clinical manager.

Areas allocated to medicines management are appropriate and secure. Medicines are kept in a medicines cupboard inside locked medicines rooms. The controlled drug register is maintained and staff complete a review of controlled drug stock at weekly intervals. Controlled drugs are stored in a secure, locked safe inside each medicines room. The controlled drug register is maintained and six monthly physical stock takes of controlled drugs by pharmacist. Two lunch time medication round were observed. All resident medicines charts reviewed comply with legislation as well as safe practice guidelines. Medicines management training occurred twice within the previous 12 months. The service has four residents who are competent to self-administer inhalers.

Food policies and procedures and services are appropriate to the service setting. The service provides summer and winter menus that rotate every four weeks. The menu is developed by a dietitian. The cook is informed when resident's dietary needs change. Additional food and snacks are available for residents and offered fluids throughout the day. Staff members monitor resident's weights at monthly intervals. There is a requirements for improvement relating to food, fluid and nutritional needs of residents to be met.

### Safe and Appropriate Environment

The facility has two hospital wings, one rest home wing and a dementia wing. With the exception of 15 hospital bedrooms, all bedrooms provide single accommodation. All of the rest home bedrooms and some of the hospital rooms have full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility.

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

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

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

### Restraint Minimisation and Safe Practice

The service has systems in place to ensure restraint use is minimized. There are 15 restraints and no enablers being used by residents. Restraint minimisation and safe practice as well as challenging behaviour training takes place annually. Restraint consents, reviews and restraint risks are identified and recorded. There are processes for determining restraint approval. The service has a monthly restraint committee meeting and the role of the restraint coordinator is clearly defined.

Orientation and induction programmes for new staff members include an overview of the restraint. Systems are in place to ensure rigorous assessment of residents is undertaken prior to restraint use. Multidisciplinary reviews evidence restraint assessment risks are reviewed and the GP signs each restraint form. Resident files reviewed demonstrate appropriate alternative interventions are implemented and de-escalation is attempted prior to initiating restraint. Resident files reviewed include the reasons for initiating restraint, alternative interventions and advocacy and support offered. The restraint register records information to provide an auditable record of restraint use.

Policies guide the service in relation to strategies to minimise use of restraint and management of challenging behaviour. Restraint monitoring and quality review occurs three monthly. Restraints are discussed at the monthly staff meetings.

### Infection Prevention and Control

Interviews with the registered nurses and health care assistants confirm they are able to identify the infection control coordinator. Infection control meetings are held monthly and fed back to staff members at the monthly staff meeting. The infection control coordinator has a documented job description with responsibilities relating to the role. The Infection control program is maintained and updated by the organisation. The infection control meetings are part of the health and safety meetings. The infection control coordinator completed a post graduate paper in Infection Prevention and Control in 2011 and is responsible for internal training relating to infection prevention and control.

Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice. The infection control coordinator is also involved in continuous improvement projects relating to infection control. Staff education relating to infection control and hand hygiene is conducted by the infection control coordinator. New staff members receive orientation packs which include the management of infections in the service. The service had a Noro virus outbreak in April 2014. Seventeen residents and three staff members were affected by the virus. The outbreak was managed in a very comprehensive and affective manner.

Surveillance is carried out in accordance with the service’s infection control policies. Reports include collated data which is reported to support office as part of the quality indicators. The surveillance data is analysed at clinical and quality management level and internally benchmarked.

# 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:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Eldon Lodge |

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

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| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Eldon Lodge Rest Home and Hospital | | | |
| **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:** | 5 May 2014 | **End date:** | 6 May 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 116 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8.5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 15.5 | Total audit hours | 47.5 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 25 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 11 | Number of staff records reviewed | 12 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 22 | Total number of staff (headcount) | 106 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 2 |

## **Declaration**

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

I confirm that:

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

Dated Thursday, 8 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Eldon Lodge Rest Home and Hospital (Eldon) provides residential care for up to 133 residents who require hospital, rest home and dementia level care. Occupancy on the day of the audit is at 116. The facility is operated by Oceania Care Company Limited. Staffing is stable with minimal turnover and staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided.  There have been no changes to the building, staffing structure, management or systems since the last audit. Continuous improvements have been noted during this audit relating to all aspects of service delivery with the exception of the food service which has been identified as an area that requires some improvement. |

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

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| **Outcome 1.2: Organisational Management** |
| Oceania Care Company Limited is the governing body and is responsible for the service provided at Eldon. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Eldon including regular monthly reporting by the facility manager and the clinical manager to the Oceania head office. The facility is managed by a suitably qualified and experienced facility manager who is a registered nurse with extensive aged care experience. The facility manager is supported by a clinical manager who is a registered nurse and who is responsible for oversight of clinical care provided. The clinical manager is supported by four charge nurses, one for each of the four areas, who are senior registered nurses.  The Oceania Care Company Limited quality and risk management systems are in place at Eldon. There is extensive evidence available indicating that quality improvement data is being collected, collated, and comprehensively analysed to identify trends and improve service delivery. There is an internal audit programme in place and there is evidence that corrective action plans are developed, implemented and monitored to address any areas identified as requiring improvement. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms as well as on an electronic database that is able to be reviewed by personnel from Oceania’s support office.   There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. Inservice education is provided for staff on a daily basis and staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ‘Oceania Certificate in Residential Care’. A review of staff records provides evidence that human resources processes are being followed (eg, reference checking, criminal record vetting, and interview questionnaires are completed), orientations are being completed and individual education records are maintained.  There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two registered nurses and six health care assistants. The facility manager and/or the clinical manager are on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work.   Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has policies and procedures to guide entry criteria, assessment and screening. The admission agreement defines the scope of service and access and entry processes are followed. The service has an admission pack available for residents who are new and for their family. The service has a system in place for informing people who are declined to the service. Residents receive timely, competent and appropriate services meeting their assessed needs. Residents are involved in assessments, care planning and review of care.   Risk assessments are completed on admission and recorded in care plans. Goals are identified by residents and service providers and reviewed at six monthly intervals or when needs change. Resident files sampled evidence the clinical interventions, treatment, support and care provided by the staff is current. GP records are current. The diversional therapists and the activities coordinator plan and implement the activities with a focus on the resident’s abilities, interests and needs. Residents in the dementia unit have 24 hour challenging behaviour management plans to guide the service as part of their assessments completed. Evaluation of person centred care plans are within required timeframes and reviewed. Family are notified of changes in resident's condition. Resident files reviewed show evidence of input from other services such as specialists. Multidisciplinary reviews are current. Transitions, exits, discharge and transfers are planned and coordinated by the RN’s or the clinical manager.  Areas allocated to medicines management are appropriate and secure. Medicines are kept in a medicines cupboard inside locked medicines rooms. The controlled drug register is maintained and staff complete a review of controlled drug stock at weekly intervals. Controlled drugs are stored in a secure, locked safe inside each medicines room. The controlled drug register is maintained and six monthly physical stocktakes of controlled drugs by pharmacist. Two lunch time medication round were observed. All resident medicines charts reviewed comply with legislation as well as safe practice guidelines. Medicines management training occurred twice within the previous 12 months. The service has four residents who are competent to self-administer inhalers.   Food policies and procedures and services are appropriate to the service setting. The service provides summer and winter menus that rotate every four weeks. The menu is developed by a dietitian. The cook is informed when resident's dietary needs change. Additional food and snacks are available for residents and offered fluids throughout the day. Staff members monitor resident's weights at monthly intervals. There is a requirements for improvement relating to food, fluid and nutritional needs of residents to be met. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has two hospital wings, one rest home wing and a dementia wing. With the exception of 15 hospital bedrooms, all bedrooms provide single accommodation. All of the rest home bedrooms and some of the hospital rooms have full ensuite facilities. There are also adequate toilet and shower facilities throughout the facility.   Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There are separate lounges and dining areas throughout each area of the facility. External areas are available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.  There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and is used by staff.  Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has systems in place to ensure restraint use is minimized. There are 15 restraints and no enablers being used by residents. Restraint minimisation and safe practice as well as challenging behaviour training takes place annually. Restraint consents, reviews and restraint risks are identified and recorded. There are processes for determining restraint approval. The service has a monthly restraint committee meeting and the role of the restraint coordinator is clearly defined.   Orientation and induction programmes for new staff members include an overview of the restraint. Systems are in place to ensure rigorous assessment of residents is undertaken prior to restraint use. Multidisciplinary reviews evidence restraint assessment risks are reviewed and the GP signs each restraint form. Resident files reviewed demonstrate appropriate alternative interventions are implemented and de-escalation is attempted prior to initiating restraint. Resident files reviewed include the reasons for initiating restraint, alternative interventions and advocacy and support offered. The restraint register records information to provide an auditable record of restraint use.   Policies guide the service in relation to strategies to minimise use of restraint and management of challenging behaviour. Restraint monitoring and quality review occurs three monthly. Restraints are discussed at the monthly staff meetings. |

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| **Outcome 3: Infection Prevention and Control** |
| Interviews with the registered nurses and health care assistants confirm they are able to identify the infection control coordinator. Infection control meetings are held monthly and fed back to staff members at the monthly staff meeting. The infection control coordinator has a documented job description with responsibilities relating to the role. The Infection control program is maintained and updated by the organisation. The infection control meetings are part of the health and safety meetings. The infection control coordinator completed a post graduate paper in Infection Prevention and Control in 2011 and is responsible for internal training relating to infection prevention and control.   Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice. The infection control coordinator is also involved in continuous improvement projects relating to infection control. Staff education relating to infection control and hand hygiene is conducted by the infection control coordinator. New staff members receive orientation packs which include the management of infections in the service. The service had a Noro virus outbreak in April 2014. Seventeen residents and three staff members were affected by the virus. The outbreak was managed in a very comprehensive and affective manner.   Surveillance is carried out in accordance with the service’s infection control policies. Reports include collated data which is reported to support office as part of the quality indicators. The surveillance data is analysed at clinical and quality management level and internally benchmarked. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 100 | 0 | 1 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | Three of six family members interviewed, five of eight residents interviewed and experience of the auditor during the onsite audit confirm meat being tough and not tasty. | To ensure that food, fluids and nutritional needs are met. | 180 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive training in the Code of Health and Disability Services Consumers’ Rights’ (the Code) at least annually (records are sighted). Care staff are observed interacting respectfully and communicating appropriately with residents. Staff allow residents to make choices demonstrating their knowledge of residents’ rights.   Residents (four hospital and four rest home) and family member (three hospital and three dementia) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. These findings are also confirmed during review of the resident and family survey that was completed in April/early May 2014 and the collated results indicate high levels of satisfaction with this aspect of service delivery.  Interviews with staff (the facility manager, clinical manager, four registered nurses, 12 health care assistants, two diversional therapists and one activities coordinator) demonstrate an understanding of resident rights. Education records reviewed indicate that staff attend training in resident rights as part of their orientation as well as part of the ongoing education programme. This education was last provided in October 2013 and was attended by 92 members of staff.  The district health board contract requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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:** |
| The Code of Rights and information on the advocacy service are displayed and are available at the facility and in the information pack provided on admission to the facility.   Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident’s admission. The admission pack is reviewed and contains, but is not limited to, information on the Code, advocacy and complaints processes. Residents and family interviewed confirm explanations regarding their rights occur on admission and at any time that they may have a query.  The families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and 11 admission agreements are reviewed as part of the review of resident’s files and all are found to contain this level of information.  Residents interviewed confirm they have access to an advocate and one may be appointed if needed. Resident meeting minutes dated 18 February 2014 reviewed and indicates one of the two independent advocates discussed their role as an independent advocate during this meeting as well as discussing the Code.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are observed being treated with respect by staff during this audit and these findings are confirmed during interviews of residents (four hospital and four rest home) and family members (three hospital and three dementia) and during review of resident and family satisfaction survey that has just been completed in April / early May 2014. Collated results indicate 100% of respondents are satisfied with resident care, including staff respecting their privacy.  Staff receive training on abuse / neglect and the last education session for staff was provided in December 2013. Staff are observed knocking before entering residents' rooms and keeping doors closed while attending to residents.   Activities in the community are encouraged and several residents attend community events independently. Where a resident wishes to continue with their hobbies or self-cares this is encouraged. Church services are held on site as part of the activities programme.  Values, beliefs and cultural aspects of care are recorded in residents’ clinical files reviewed (six hospital, two dementia and three rest home).   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau).   There is one resident in the facility that identifies as Māori and their file is reviewed during this audit. A cultural assessment is completed as part of the person centred care plan for all residents and is reviewed on the file for the resident who identifies as Māori as well as on the other resident’s files.   Access to Māori support and advocacy services is available if required via family members of residents and from a Kaumatua from the local iwi. Family are able to be involved in the care of their family member. Interview of one resident who identifies as Māori confirms their cultural values and beliefs are met.  Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education was last provided in November and December 2013 and was attended by 80 staff.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures in place that outline the safeguards to protect residents from all forms of abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and a code of conduct that includes house rules. These documents also address any conflict of interest issues (e.g. the accepting of gifts and personal transactions with residents) and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which are reviewed on 12 staff files. Registered and enrolled nurses have recently attended Code of Conduct education that New Zealand Nursing Council requires all nurses to attend.  A review of the accident/incident reporting system, complaints register and interview of the facility manager indicates there have been no allegations made against staff alleging unacceptable behaviour.   Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes they are required to adhere to. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families and are reviewed. Residents' files reviewed (three rest home, two dementia and six hospital) provide evidence that communication with family members is being documented in residents' records. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, on family communication sheets, and in the individual resident's files.   Residents and family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.  The facility manager advises access to interpreter services is available if required via the local community, family members and interpreter services if required. They also advise there are currently two residents who require interpreter services and that staff and family provide this service. Posters are observed on one resident’s bedroom wall with commonly used phrases in English and the resident’s own language.   The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Eleven admission agreements are reviewed and this was clearly communicated in each agreement.   The district health board contract requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The facility manager, clinical manager and RNs report informed consent is discussed and is recorded at the time the resident is admitted to the facility.   Residents/family are provided with various consent forms on admission for completion as appropriate and are reviewed on 11 resident’s files (three rest home, six hospital and two dementia). Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these are reviewed on resident’s files.  Staff interviewed (12 health care assistants, four RNs, the facility manager and the clinical manager) demonstrate a good understanding of informed consent processes.   Residents (four hospital and four rest home) and family (three hospital and three dementia) interviewed confirm they have been made aware of and understand the principles of informed consent, and confirm informed consent information has been provided to them and their choices and decisions are acted on.   Residents' files reviewed demonstrate written and verbal discussions on informed consent have occurred and all residents' files evidence signed informed consent forms. Residents' admission agreements are signed. Staff education programme includes education on the Code of Rights and was last provided in October 2013.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates and these are reviewed.   Care staff interviewed demonstrate an understanding of how residents can access advocacy/support persons. Care staff interviewed confirm they attended education on the Code of Right, advocacy, and complaint management as part of the inservice education programme. This was confirmed during review of staff education records.   Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission. Visual inspection provides evidence the Nationwide Advocate details are displayed along with advocacy information brochures. Admission pack is reviewed and provide evidence advocacy, complaints and Code of Rights information is included.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes five complaints for 2014 and six for 2013 and the complaints register is reviewed.   The facility manager advises there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.   Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents (four hospital and four rest home) and family (three hospital and three dementia) interviewed demonstrate an understanding and awareness of these processes. Resident meetings are held three monthly and residents are able to raise any issues they have during these meetings and this is confirmed during interview of residents and review of meeting minutes.  A visual inspection of the facility provides evidence that the complaint process is readily accessible and/or displayed. Review of combined quality and staff meeting minutes and the facility manager’s monthly reports provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm this information is reported to them via quality/staff meetings and that graphs of this data is displayed on the noticeboard in the staff room.  The district health board contract requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Eldon Lodge Rest Home and Hospital (Eldon). The Oceania quality and risk management systems are fully implemented at Eldon and the documented scope, direction, goals and vision are reviewed.   Systems are in place for monitoring the service provided at Eldon including regular monthly reporting by the facility manager and the clinical manager to Oceania support office via the Oceania intranet. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators and is sighted during this audit. The monthly business status reports are sighted and these reports are provided to the Oceania executive team and link to the organisations and facility’s business plan.  A written quality and risk management plan/policy identifying the organization’s quality goals, objectives, and scope of service delivery is reviewed and includes statements about quality activities and review processes. A 'Clinical Risk Management Policy' and a 'Clinical Risk Management Plan' are reviewed along with documented values, mission statement and philosophy, which are displayed at the main entrance. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.   The facility manager is a very experienced registered nurse and has been in this position since August 2005. The facility manager is supported in their role by a clinical manager who was appointed to this position in August 2008. These two managers are supported by an Oceania clinical and quality manager as well as a regional business operations manager from Oceania. Both managers are registered nurses with current practising certificates. The managers' CVs and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.   Eldon is certified to provide hospital (medical and geriatric) and rest home level care (including dementia care) and have contracts with the district health board (DHB) to provide aged related residential care (rest home, hospital and dementia level care), aged respite care, day care, long term support - chronic health conditions services, and with the Ministry of Health to provide residential non-aged services. On day one of this audit there are 21 residents assessed as requiring rest home level care (one aged less than 65 years); 78 residents assessed as requiring hospital level care (six aged less than 65 years); and 17 residents assessed as requiring dementia level care.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are appropriate systems in place to ensure the day-to-day operations of the service continues should the facility manager and/or the clinical manager be absent. The clinical manager relieves the facility manager if they are absent, with support from the administrator, and the facility manager relieves the clinical manager if they are absent. A senior registered nurse relieves if both managers are absent with support from one of the clinical and quality managers from Oceania. Twenty four hour registered nurse (RN) cover is provided. Both the facility manager and clinical manager are on call after hours if required.  Additional support and assistance is provided by other personnel from Oceania support officeas required. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the facility manager and clinical manager confirms their responsibility and authority for their roles.   The district health board requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A 'Quality Improvement Policy', 'Clinical Risk Management Policy' and a '2014 Quality Audit Schedule' are used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place, risks are identified and there is a hazard register. Clinical indicators are documented on an electronic database that is able to be reviewed by personnel from Oceania Support Office. The Oceania clinical and quality team meet monthly and review the clinical and quality data, review policies and procedures, and clinical documentation.  Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff report copies of policies are available in the nurses stations in each of the four areas of the facility. Staff also report they are advised of updated policies via the combined staff / quality meetings. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery.  Internal audit schedules and completed audits for 2013 and 2014 are reviewed during this audit. Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. Review of the quality improvement data provides evidence the data is being collected, collated, evaluated, and comprehensively analysed to identify trends and that this data is being reported to staff and to the governing body. Combined quality and staff meetings are held monthly as are health and safety and infection control meetings. Registered nurse meetings are held six weekly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interviews that copies of meeting minutes and print outs of clinical indicators from the Oceania intranet are available for them to review in each of the nurses stations. They also report graphs of the clinical indicators are displayed on the noticeboard in the staff room. This is confirmed during visual observations during this audit. Also reviewed in the staffroom is a copy of the staff survey that was completed in late 2013 by an external agency and the results presented to staff in April 2014. Review of the collated results for this survey indicates that Eldon exceeds the benchmark for other Oceania facilities and for a large organisation that Oceania has been benchmarked against.  Several quality improvement projects are reviewed during this audit and include but are not limited to projects for: workforce development; prevention of falls in the dementia unit; an infection control project; and an administration project to improve storage of archived records.  The resident / relative satisfaction survey was completed in late April/ early May 2014 and the manager has collated and analysed the results and developed corrective actions. The facility manager advises that these results will be presented to the next residents meetings. The results indicate that residents and family are 100% satisfied with resident care. Issues relating to the quality of the meals have been raised in this survey (see link criterion 1.3.13.1)   The health and safety manual documents health and safety management systems including a health and safety plan, employee participation, audits, accident reporting, injury management, hazard management, contractor agreements, and an emergency plan. The hazard register is reviewed during this audit. Meeting minutes are reviewed and provide evidence of discussion and reporting on accident/ incidents; hazards; staff wellness programme, health and safety objectives and maintenance. Oceania holds Workplace Safety Management Practices accreditation at tertiary level for ACC workplace safety and this expires on 31st March 2015.   Chemical Safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed: all biomedical equipment has appropriate performance verified stickers in place.  The district health board contact requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an adverse event reporting system in place. All accident/incidents are recorded on an ‘Incident/Accident Reporting Form’. The clinical manager also enters these accidents and incidents on the Oceania intranet as part of the reporting of monthly clinical indicators. Incidents recorded include but are not limited to incidents relating to absconding, choking, falls, infections, medication errors, sentinel events, wounds, and abuse. An ‘Incident/Accident’ internal audit was last conduced in April 2014.  A falls project has been implemented as part of the quality improvement programme with the aim of reducing the number of falls and this data is reviewed during this audit.   Resident files reviewed provide evidence that incident accident forms are completed as well as general observations being recorded for residents following falls. ‘Neurological Observation Chart’ and ‘Fall – Post Assessment Form’ are also completed for residents who have falls.  Communication with families following adverse events, or any change in resident’s condition is evidenced in the residents’ files reviewed. Staff education on communication and documentation was held throughout June to September 2013. During interviews staff demonstrate an awareness of the adverse event process.  Staff are made aware of their essential notification responsibilities through their job descriptions, Oceania policies and procedures and professional codes of conduct.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility manager and clinical manager are responsible for oversight of the inservice education programme and education for staff is provided via daily education sessions. The facility manager advises education is provided daily because of the large number of staff employed at Eldon and the need to ensure all staff have the opportunity to attend the education that is repeated several times over the month. Staff are required to attend at least the compulsory education sessions each year to progress through the Oceania career pathway programme. Inservice education plans, staff competency registers and staff education records are maintained and are reviewed for 2013 and 2014.   The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (12 of 12) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.  There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed.   Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the ‘Oceania Certificate in Residential Care’ programme. All care staff working in the dementia unit have commenced or completed the dementia specific unit standards.  Twelve of 12 health care assistants interviewed working in all areas (nine working morning shifts and three working afternoon shifts) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals. Registered nurses (RNs) and enrolled nurses (ENs) attend compulsory education at the DHB and all RNs have completed the professional development and recognition programme (PDRP) via the DHB.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented rationale (‘Interim Staffing Policy’) which is supplemented by an ‘Interim RN Shortage Policy', for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two registered nurses (RNs) and six health care assistants (HCAs). The facility manager and/or the clinical manager are on call after hours.  One HCA is based in the rest home area, four HCAs in the hospital and one HCA in the dementia unit. The two registered nurses are based in the hospital wings; one in each wing. The RNs are available to the rest home and dementia HCAs as required. Each area always has at least one staff member available.   Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirms adequate staff cover is provided.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures for entry criteria, assessment and entry screening. The service’s philosophy is recorded and displayed at the facility, residents confirm they are familiar with and receive this as part of the information pack on admission. The service provides information to referral sources and operates over the 24 hour period. The admission agreement defines scope of service and includes all the contractual requirement, eleven sampled files (six hospital, three rest home and two dementia unit) evidenced signed and dated admission agreements, sighted.  Access and entry processes are followed, confirmed at the clinical and quality manager’s interview. The service has an admission pack available for residents and their family who are new to the facility. Residents' files sampled demonstrate needs assessments are completed for appropriate level of care (six hospital, three rest home and two dementia unit files reviewed). Interviews with eight residents and six family members confirm that staff members discuss care and treatment with residents. The district health board contract requirements are met. |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The scope of the service provided by the service is identified and communicated to prospective residents and their families. The service has a system in place for informing people who are declined to the service, confirmed during the clinical and quality manager and the clinical manager’s interviews. The clinical manager states resident will be declined entry if not within the scope of the service or if there is no bed available at the time of the enquiry. People who are declined to the service are informed of the reasons for decline of entry and referred back to the NASC assessment team, confirmed at the facility manager’s interview. The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents receive timely, competent and appropriate services meeting their assessed needs, confirmed during eight residents and six family interviews.  The stages of service provision is undertaken by a suitably qualified experienced clinical manager and clinical team. The stages of service provision occurs within the required timeframes. The service is coordinated in a manner that promotes continuity of service delivery and the clinical manager confirms that the clinical team work well together. The district health board contract requirements are met.  Tracer methodology completed in the Hospital: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology completed in the Rest Home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology completed in the Dementia Unit: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **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:** |
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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 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner, reviewed resident files of six hospital, three rest home and two dementia unit residents. The service access information through interviews with family members, GP’s, specialists and other referrers. Eleven residents' files sampled evidence discharge and or transfer information from hospitals or NASC assessors. The registered nurse interviews confirms that assessments are conducted in the resident’s bedrooms. Eight residents and six family members interviewed confirm their involvement in assessments, care planning, and review of care. Risk assessments are completed on admission and recorded in care plans, sighted risk assessments for all resident files reviewed. Initial care plans are recorded on admission and the long term care plan is developed within three weeks of admission. Eleven person centered care plans reviewed are evaluated at six monthly intervals or when resident's condition alters, sighted. The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Eleven resident files sampled evidence person centered care plans (PCCP) are comprehensive, individualised and up-to-date. The goals are identified by the residents and service providers and reviewed at six monthly intervals or when needs change. Residents confirm they have input into their care planning and review, confirmed at four resident interviews. Resident files sampled evidence the clinical interventions, treatment, support and care provided by the staff is current, sighted risk assessments, progress notes, PCCP’s, medical records and doctor’s notes. Risk assessments are reflected in the PCCP’s and there is evidence of it being discussed with and sign off by residents and family members. The facility has access to two GP’s who attend to residents on a daily basis. Interview with both GP’s confirm they are satisfied with the levels of care provided by the service. RN and HCA interviews confirm that care plans are being used for guidance regarding the care of residents and review of eleven resident care plans confirm it being resident focussed, integrated and promoting continuity of service.  The district health board contract requirements are met. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents receive adequate and appropriate services in order to meet their assessed and desired needs. Eleven resident files reviewed evidence the PCCP records interventions based on the assessed needs as identified through risk assessments and the resident’s desired outcomes and goals. GP records are current. Visual inspection of the facility and services confirm adequate continence and dressing supplies in accordance with their Service Agreement. Eight residents interviewed confirm that care and treatment meet their needs.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The diversional therapists (one in the hospital and one in the dementia unit) and the activities coordinator (AC) in the rest home plan and implement the activities with a focus on the residents abilities, interests and needs. The diversional therapist (DT) in the hospital works 40 hours per week, the diversional therapist in the dementia unit works 25 hours per week and the activities coordinator (AC) in the rest home works 25 hours per week. The activities programme is made available to residents on a weekly basis and each resident has a copy of the programme displayed in their bedrooms. The DT’s and the AC keep attendance records for all residents and all resident files reviewed evidence current activities assessments, sighted. Residents interviewed confirm their past activities are considered during assessment activities are voluntary. The 24 hour challenging behaviour management plans are compiled by the DT in the dementia unit. Residents in the dementia unit have 24 hour challenging behaviour management plans as part of their assessments completed, sighted. The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident files sampled evidence evaluation of person centered care plans (PCCP’s) are within required timeframes (six monthly) and reviewed when the residents’ condition change. The clinical manager conducts (PCCP) reviews with input from the resident and their family members, confirmed during interview with eight resident and six family members. Family are notified of changes in resident's condition. Resident interviews confirm their participation in care plan evaluations. The resident files reviewed show evidence of input from other services such as specialists. Residents' files evidence referral letters to specialists and other health professionals. Multidisciplinary reviews are current, confirmed at the clinical manager and GP interviews and during review of eleven resident’s files. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Review of 11 resident files show documentation and records confirming referrals to other health and disability services. There are processes in place to ensure residents have choices regarding access and referrals to other services. Resident files sampled evidence referral forms and letters to nurse practitioners, medical specialists, the NASC assessment team and specialist services at the DHB. The service maintains effective family communication, confirmed during eight resident and six family interviews and supported by resident records such as the communication sheets and progress notes.  The district health board contract requirements are met. |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Eleven resident files reviewed, evidence records confirming transition, exit, discharge or transfer plans are communicated to other health and disability service providers, when required. Transitions, exits, discharge and transfers are planned and coordinated by the RN’s or the clinical manager, confirmed during the clinical manager, clinical quality manager and the RN interviews. Letters and plans for transitions, exits, discharge and transfers are located in residents' files, sighted.  ARC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection of the medication areas in the facility evidence appropriate and secure medicine storage, dispensing and disposal of medicines. Medicines are kept in a medicines cupboards inside locked medicines rooms. The service has three medicines rooms which are kept free from heat, moisture, light and medicines are stored in original dispensed packs.  The controlled drug register is maintained and staff complete a review of stock at weekly intervals. Controlled drugs are stored in a secure, locked safe inside each medicines room. Six monthly physical stock takes of controlled drugs by pharmacist are conducted, last completed in February 2014. Two lunch time medication round are observed during the days of audit, one in the hospital and one in the dementia unit. The correct procedures for administration of medicines is followed. Twenty two resident medicines charts are reviewed in a manner that complies with legislation as well as safe practice guidelines. All entries and discontinued medicines are signed and dated by the GPs, allergies and sensitivities are identified, all medicines charts have photo identification and three monthly medical reviews are conducted within required timeframes. Random review of expiry dates confirm medicines are within the timeframes of safe use.  Medicine management training occurred twice within the previous 12 months and all staff members responsible for medicines administration (21 registered nurses, one enrolled nurse and 16 health care assistants) have annual competencies completed for 2013 / 2014.  The service has four residents who self-administer inhalers. All residents who self-administer medicines have completed competency assessments and are monitored regarding them taking their medicines as prescribed. Each resident who self-administer medicines have secure storage in their bedrooms for their medicines. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Food policies and procedures and services are appropriate to the service setting, providing summer and winter menus that rotate every four weeks. The menu is developed by a dietitian, last reviewed in March 2014, confirmed by the cook during interview and sighted. Resident's individual dietary needs are identified, documented and reviewed as part of the person centered care plan (PCCP) review. The cook is informed when resident's dietary needs change, confirmed during interview and sighted copies of the dietary assessment. Additional food and snacks are available for residents. Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Residents and relatives interviewed are not satisfied with food services. The service already started implementing changes to the kitchen services by implementing quality testing (food to be tasted and feedback to be recorded prior to every lunch and evening meal.  The district health board contract requirements are fully met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Food, fluid and nutritional needs of residents are provided in line with recognised guidelines, however three of six family members interviewed, five of eight residents interviewed and experience of the auditor during the onsite visit confirm meat being tough and not tasty. |
| **Finding:** |
| Three of six family members interviewed, five of eight residents interviewed and experience of the auditor during the onsite audit confirm meat being tough and not tasty. |
| **Corrective Action:** |
| To ensure that food, fluids and nutritional needs are met. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and are accessible for staff. A hazard register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in April 2014. Monthly visits are made by the chemical supplier representative who reviews kitchen, cleaning and laundry processes and their reports are reviewed.   Sluice facilities are available throughout the facility for the disposal of waste and hazardous substances. A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in the sluice room, laundry and cleaners’ room and disposable gowns and gloves in each residents bedroom in the hospital.   Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There have not been any alterations undertaken to the building since the last audit although an ongoing refurbishment programme is in place. Review of documentation provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.   A maintenance person is employed for 37.5 hours a week and is interviewed during this audit. During interview the maintenance person confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and are reviewed during this audit along with current calibration / performance reports for medical equipment. A current Building Warrant of Fitness is displayed that is issued on 08 April 2014 and expires on 16 April each year.  A visual Inspection of the facility provides evidence of safe storage of medical equipment; the building, plant and equipment are maintained to a high standard. Corridors are wide enough in all areas to allow residents to pass each other safely. Safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; and floor surfaces and coatings are maintained in good order.   The facility manager advises that funding to upgrade some of the external areas has been approved by Oceania support office and that the dementia unit external area will be upgraded as part of this project. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (eg, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).   Staff receive education in the safe use of medical equipment by suitably qualified personnel and there is a system in place to review staff competency for specific equipment (e.g. hoists competency). This was confirmed during interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.  Residents interviewed confirm they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.   The district health board contract requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection provides evidence that all of the hospital bedrooms and dementia bedrooms have double leaf doors that allow for easy access for mobility aids; rest home bedrooms have oversized doors. All bedrooms are large and adequate personal space is provided to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff and residents.   Resident’s bedrooms are personalised to varying degrees.   The district health board contract requirements are met. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection provides evidence that adequate access is provided to lounges and dining rooms in all areas of the facility. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons. New commercial laundry equipment has been installed since the last audit. All linen is washed on site in the laundry and there is adequate dirty / clean flow. A laundry worker is interviewed and they describe the management of laundry including transportation, sorting, storage, laundering, and return to residents.   Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning are reviewed. A cleaner is interviewed and describes the management of cleaning processes including the use of personal protective equipment.  Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.  Residents interviewed state they are satisfied with the cleaning and laundry service although they do report that at times they do not always receive their personal items back from the laundry. This finding is confirmed during review of completed family and resident satisfaction surveys. The facility manager has initiated a project to address this issue.   The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.   A New Zealand Fire Service (NZFS) letter dated 31 March 1999 is sighted advising the fire evacuation scheme has been approved. There was a false alarm on 14 February 2014 resulting in a trial evacuation. Prior to this fire safety education was held on 28 April 2014.   Registered nurses, diversional therapists and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training.   Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Emergency management training was last provided in April 2013.   Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.   A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.   A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.   A new call bell system has been installed that is used by the resident or staff members to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond to it in a timely manner.   The district health board contract requirements are met. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has systems in place to ensure restraint use is minimized. The facility was utilising 15 restraints during the onsite audit days and there was no use of enablers. Staff interviews and records evidence restraint minimisation and safe practice (RMSP) as well as challenging behaviour training took place in February 2014. The process of assessment and evaluation of restraint use is recorded.  Review of all the restraints occurred. Fifteen resident files were reviewed for restraint consents, restraint reviews by the service and whether restraint risks are identified. All restraints are documented in the person centered care plans (PCCP). Care plan entry evidences records of enabler risks and monitoring guidelines. The district health board contract requirement is met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are processes for determining restraint approval. Staff members interviewed and residents' files sampled evidence responsibilities are clearly identified and recorded. Residents' files sampled evidence input into the restraint approval processes from resident’s and family members.  The service has a monthly restraint committee meeting, sighted meeting minutes from January to April 2014. The restraint committee evidence an approval review process. The role of the restraint coordinator (RC) is the responsibility of the clinical manager who are suitably experienced and qualified. Clinical staff members are aware of the restraint co-ordinator's responsibilities. Orientation and induction programmes for new staff members include an overview of the restraint minimisation and safe practice (RMSP) policies and procedures.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Systems are in place to ensure rigorous assessment of residents is undertaken prior to restraint usage being implemented, sighted restraint assessments for 15 residents. Residents' files sampled demonstrate restraint assessment and risk processes are being followed. Residents' files sampled, where restraint is utilised, evidence restraint assessment risks are documented and evaluated three monthly or when the resident’s needs change and include resident and / or family input. Multidisciplinary reviews evidence restraint assessment risks are reviewed and the GP signs each restraint forms, sighted and confirmed at the GP interviews. Restraint' audit was conducted in July 2013 and there were no corrective actions identified. The district health board contract requirements are met. |

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

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

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

#### Standard 2.2.3: 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:** |
| The service has systems in place to ensure restraint is used safely. Restraint policies and procedures identify risk processes to be followed when a resident is being restrained. The monthly reports to the support office include data on restraint use. Residents' files sampled evidence evaluations / review of restraint goals and interventions. Fifteen residents' files reviewed for restraint demonstrate appropriate alternative interventions are implemented and de-escalation is attempted prior to initiating restraint. Residents' files reviewed demonstrate details of the reasons for initiating the restraint, alternative interventions attempted or considered prior to the use of restraint and advocacy/support services offered. The restraint register records information to provide an auditable record of restraint use. During the onsite days of audit there were fifteen residents utilising restraint and no residents requesting the use of enablers. Staff education in challenging behaviour by the Capital and Coast District Health Board (CCDHB) and the clinical manager occur annually. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility’s restraint evaluation processes are documented in the restraint minimisation and safe practice policy (RMSP). Fifteen residents' files reviewed for restraint, evidence that each episode of restraint is being evaluated and based on the risk of the restraint being used. Policies guide the service in relation to strategies to minimise use of restraint and management of challenging behaviour. The restraint committee meeting minutes for January to April 2014 are sighted. Evaluations of restraint include (a) to (k) in this criterion. Fifteen residents' files reviewed for restraint practices demonstrate residents' person centered care plan (PCCP) evaluations and multidisciplinary meetings are current. The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Restraint monitoring and quality review occurs three monthly, reviewed 15 resident files. Restraint reviews are documented and reported on to support office at Oceania Care Group as part of the quality indicators. Restraints are also discussed at the monthly staff meetings. The RMSP policies and procedures include monitoring and quality review processes. The restraint committee meeting minutes for January to April 2014, sighted.  The district health board contract requirements are met. |

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

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

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

# NZS 8134.3:2008: 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:** |
| Interviews with the registered nurses (RN’s) and health care assistants (HCA’s) confirm they are able to identify the infection control coordinator who is also the manager of the facility. Infection control meetings are held monthly and feedback is given to staff members at monthly staff meetings. The infection control coordinator (ICC) has a documented job description with responsibilities relating to the role, sighted. The responsibilities of the infection control coordinator includes monitoring and surveillance of infections on a monthly basis, collating the information and including the data in the monthly report to the support office of the Oceania Care Group. Data is reported as part of the key quality indicators. The Infection control program is maintained and updated by the organisation. Alcohol hand gel is available throughout the facility and at the front reception for use.  The district health board contract requirement is met. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control meetings are part of the health and safety meetings and are held monthly, confirmed during interview of the infection control coordinator (ICC). The infection control coordinator completed a post graduate paper in Infection Prevention and Control in 2011 and in 2013 attended Infection Prevention and Control training offered by the capital coast district health board (CCDHB), where she is a member of the Infection control Group. The ICC is responsible for internal training relating to infection prevention and control. The service has posters and signs throughout the facility to remind residents, their families and staff members of the importance of hand washing and the prevention of infection. The district health board contract requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice. The infection control coordinator is also involved in continuous improvement projects relating to infection control. Projects include: improvement of staff understanding of basic infection control and prevention and improvement of staff understanding of the management of multi drug resistant organisms (MDRO’s). The district health board contract requirements are met. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A review of the education folders by the lead auditor shows that training was provided by the infection control officer during April 2013, included infection control and hand hygiene education and was repeated in April 2014. In May 2013 the infection control coordinator offered an advanced course in infection prevention and control training to staff members, sighted training records. Interviews with residents and resident families show they are aware of the importance of hand washing and the use of alcohol gels. The service offers education and training regarding hand washing procedures to residents. New staff members receive orientation packs which include the management of infections in the service.  The district health board contract requirement is met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service had a Noro virus outbreak in April (20th to the 27 of April). The outbreak was the first outbreak in three years. Seventeen residents in the west wing of the service contracted Noro virus and the service was able to contain it within the west wing. Three staff members were affected by the virus, sighted the outbreak register. The CCDHB, the Public Health Officer, HealthCERT and Oceania support office were informed of the outbreak. The service went into lockdown for one week, sighted supporting documentation. The facility manager who is also the infection control coordinator compiled an outbreak management plan that included the location of the outbreak, the senior staff and their contact details and the outbreak coordinators and their contact details, staff members who may be delegated by the outbreak coordinator, staff members assigned to specific duties, the method used to advise management of the outbreak, locations of the outbreak management plans, location of outbreak supplies, location of additional outbreak stores, contact details for regional public health, location of other outbreak information and guidelines and a checklist for outbreak management resources. The outbreak was managed in a very comprehensive and effective manner.   Interview with the infection control coordinator confirms surveillance is carried out in accordance with the service’s infection control policies. The monthly infection control reports for January to April 2014 are reviewed. The reports include the total number of infections according to type, for the time period, the area it appeared in, if a specimen was collected and whether antibiotics were started. The management of infections include residents having short term care plans to guide the service.  The surveillance data is expressed in reports to the support office and analysed at clinical and quality management level and internally benchmarked. |

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

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

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

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

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

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