

# The Ultimate Care Group Limited - Mount Victoria Lifecare

---

Current Status: 5 June 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

Mt Victoria Lifecare is a part of the Ultimate Care Group (UCG). UCG have a chief executive officer (CEO) to manage an executive team who support their 16 facilities. Mt Victoria Lifecare is an aged care residential facility located in the Newtown area of Wellington city and holds a district health board (DHB) contract to provide rest home and hospital level care. It has a total of 51 beds, four of which are vacant on the day of audit. Thirty current residents are receiving hospital level care while the remaining 17 residents receive rest home level care. The facility is fully staffed with 48 people employed by the facility. A full time manager has responsibility for day to day management with a clinical services manager who has clinical oversight responsibilities. A national team supports the facility and the audit and compliance manager (ACM) was on site for both days of the audit. During audit only one area for improvement is found. The current archiving system needs reviewing and a more effective and efficient system implemented.

## Audit Summary as at 5 June 2014

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 5 June 2014

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

### Organisational Management as at 5 June 2014

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

### Continuum of Service Delivery as at 5 June 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

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

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

### Restraint Minimisation and Safe Practice as at 5 June 2014

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

## Infection Prevention and Control as at 5 June 2014

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

## Audit Results as at 5 June 2014

### Consumer Rights

Care provided to residents at Mt Victoria Lifecare is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Mt Victoria Lifecare currently cares for residents who identify as Maori and has appropriate policies, procedures and community connections to ensure culturally appropriate support is provided.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is known to the service and facilitates regular residents' meetings. Mt Victoria Lifecare encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

The effective concerns/ complaints system in place is with all response timeframes being met with many being exceeded. All issues raised in the current year are low level with all resolved satisfactorily.

### Organisational Management

Mt Victoria Lifecare is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a regional operational manager and the ACM as well as other members of the national executive team. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the activities programme, administration functions, human resources, health and safety, infection control, medication, resident care, 'releasing time to care', quality, and Maori health. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

The staff report feeling well supported by management team. A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is in place to maintain a high level of competence of all staff.

All current client records are of a very high standard, however an area for improvement is identified in the system and storage of archived records.

### **Continuum of Service Delivery**

Information packs for Mt Victoria Lifecare contain information on entry criteria, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate their family.

An active activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice.

Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

### **Safe and Appropriate Environment**

The facility is very well maintained with a full time maintenance position on staff. The residents' rooms and the communal areas are spacious very clean, airy and kept at a comfortable temperature for residents. There are adequate shower and toilet facilities. The building has a current building warrant of fitness.

Robust systems are implemented for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are well documented for ease of use and available in a number of places around the facility. Regular fire drills are held and there is a sprinkler system for use in case of fire. Access to an emergency power source is in place. A security firm is contracted to monitor the facility each night.

### **Restraint Minimisation and Safe Practice**

The organisation has a clear view that they wish to be a restraint free environment in the future and they are focused on their aim to do this. Policies and procedures that meet all the requirements of the standard are in place and are followed for all episodes of restraint. Restraint is only used as a last resort when all other options have been explored. The small number of restraints in use has decreased over time and those in place follow a comprehensive assessment,

approval and monitoring process with regular reviews occurring. The use of enablers is for safety of residents in response to individual requests. These are all monitored and reviewed regularly.

### **Infection Prevention and Control**

Mt Victoria Lifecare is able to demonstrate it provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control co-ordinator being responsible for the programme, including education and surveillance, and reporting directly to the clinical manager.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including to governance.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

---

## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	The Ultimate Care Group Limited		
<b>Certificate name:</b>	The Ultimate Care Group Limited - Mount Victoria Lifecare		
<b>Designated Auditing Agency:</b>	The DAA Group Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Mount Victoria Lifecare		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 5 June 2014	<b>End date:</b> 6 June 2014	
<b>Proposed changes to current services (if any):</b>			
	Nil		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	16	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	4

## Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52
Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	3
Number of residents' records reviewed	9	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	18	Total number of staff (headcount)	48	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group 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)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Thursday, 19 June 2014

## Executive Summary of Audit

### General Overview

Mt Victoria Lifecare is a part of the Ultimate Care Group (UCG). UCG have a chief executive officer (CEO) to manage an executive team who support their 16 facilities. Mt Victoria Lifecare is an aged care residential facility located in the Newtown area of Wellington city and holds a district health board (DHB) contract to provide rest home and hospital level care. It has a total of 51 beds, four of which are vacant on the day of audit. Thirty current residents are receiving hospital level care while the remaining 17 residents receive rest home level care. The facility is fully staffed with 48 people employed by the facility. A full time manager has responsibility for day to day management with a clinical services manager who has clinical oversight responsibilities. A national team supports the facility and the audit and compliance manager (ACM) was on site for both days of the audit. During audit only one area for improvement is found. The current archiving system needs reviewing and a more effective and efficient system implemented.

### Outcome 1.1: Consumer Rights

Care provided to residents at Mt Victoria Lifecare is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Mt Victoria Lifecare currently cares for residents who identify as Maori and has appropriate policies, procedures and community connections to ensure culturally appropriate support is provided.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is known to the service and facilitates regular residents' meetings. Mt Victoria Lifecare encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

The effective concerns/ complaints system in place is with all response timeframes being met with many being exceeded. All issues raised in the current year are low level with all resolved satisfactorily.

### Outcome 1.2: Organisational Management

Mt Victoria Lifecare is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is supported by a regional operational manager and the ACM as well as other members of the national executive team. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the activities programme, administration functions, human resources, health and safety, infection

control, medication, resident care, 'releasing time to care', quality, and Maori health. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

The staff report feeling well supported by management team. A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is in place to maintain a high level of competence of all staff.

All current client records are of a very high standard, however an area for improvement is identified in the system and storage of archived records.

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

Information packs for Mt Victoria Lifecare contain information on entry criteria, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment Service Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and where appropriate their family.

An active activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice.

Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

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

The facility is very well maintained with a full time maintenance position on staff. The residents' rooms and the communal areas are spacious very clean, airy and kept at a comfortable temperature for residents. There are adequate shower and toilet facilities. The building has a current building warrant of fitness.

Robust systems are implemented for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are well documented for ease of use and available in a number of places around the facility. Regular fire drills are held and there is a sprinkler system for use in case of fire. Access to an emergency power source is in place. A security firm is contracted to monitor the facility each night.

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

The organisation has a clear view that they wish to be a restraint free environment in the future and they are focused on their aim to do this. Policies and



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Negligible			
HDS(C)S.2008	Criterion 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.	PA Negligible	Currently there is no management system for records which are archived on site.	Provide evidence of an appropriate system to manage archived records.	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

**Attainment and Risk:** FA

**Evidence:**

Mt Victoria Lifecare ( Mt Vic Lifecare) is observed to provide an environment in which residents receive services in accordance with human rights legislation. Management (three of three) and staff (12 of 12) are familiar with the Code of Health and Disability Services Consumers' Rights (the Code) as evidenced during conversation with them and in sighted policy documents.

Staff receive education on the Health and Disability Commissioner's Code at orientation and through in-service training as sighted in staff records (seven of seven staff files, orientation and training records) and planned education programmes, and verified by interviews with staff. Residents (two of two hospital residents, four of four rest home residents) and family/whanau (two of two hospital residents' family/whanau and two of two rest home residents family/whanau) interviewed verify the service complies with consumer rights legislation.

Clinical staff (eight of eight) are observed to explain procedures being undertaken, seek verbal acknowledgement for a procedure to proceed prior to it being commenced, protect residents' privacy (eg, notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and address residents by a preferred name.

Compliance with the Code is monitored through resident and relative satisfaction surveys.

The ARRC 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.

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

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

Consumers are informed of their rights.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Mt Victoria Lifecare provides an environment in which residents are informed of their rights. Policy documents inform the information and communication details that residents / family / whanau will be provided with information on entry to the service.</p> <p>Residents are made aware of the Health and Disability Commissioner's (HDC) Code and the Nationwide Health and Disability Advocacy Service with information brochures clearly displayed and accessible to all residents (sighted).</p> <p>Residents receive a copy of the Code and the Nationwide Health and Disability Advocacy service in the admission information pack, with opportunities for discussion, clarification and explanation available at preadmission, admission and any other time as necessary. Information is also provided on access to support services, information on long term residential care for older people, information on applying for a residential care subsidy, and the facility's range of services and costs. Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time.</p> <p>Advice on accessing interpreters is available (sighted) should assistance be required to provide the information in a language and format that is suitable to the resident</p> <p>The facility has a resident's advocate (interviewed) who is onsite twice a week and runs the residents' meetings.</p> <p>Compliance with this is verified by staff, residents and family interviews.</p> <p>The Information and Communication policy and the guidelines for communicating with residents, relatives and visitors provide guidance for staff to provide full information</p>

at entry to the service and as and when required during service delivery.

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

Mt Victoria Lifecare provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. Bedrooms are of a size that allows appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms, or phones located around the facility in quiet areas, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff always knock on their door prior to entering. The nurses' stations provide privacy of stored information. Privacy when discussion concerning residents takes place in residents' rooms or in one of the many private lounge areas or the whanau room. Staff education on privacy takes place at orientation and during in-service education (provided in April 2014).

Residents receive services that are responsive to their needs, values and beliefs.

Care plans (five of five hospital and four of four rest home files reviewed) identify residents' like and dislikes and interventions identify the assistance the resident requires to meet their needs, while being encouraged to be as active as possible.

Residents are addressed in a respectful manner and by their preferred names (observed), are assisted to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.

Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The individual employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents and families have expressed no concerns related to abuse or neglect. All comments are positive. Education on abuse and neglect was presented in March 2014.

Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives.

Staff demonstrate an awareness of the need to provide a service that is responsive to these needs and evidence of this is observed, as sighted in residents' files (five of five hospital and four of four rest home) and staff files (seven of seven) reviewed and verified in resident, family and staff interviews.

There are a range of documents sighted that demonstrates an understanding of residents right to privacy, independence, respect, dignity, freedom from elder abuse and neglect and meets the requirements of the Code, the Health and Disability Services Standards (HDSS) and ARRC contract requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Mt Victoria Lifecare recognises the special relationship between Iwi and the Crown and appreciates the principles of the Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing. There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organisation’s model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. The Capital &amp; Coast DHB (CCDHB) Maori Health Development Unit supports the facility and presents education (records sighted) and advice related to cultural safety when needed. Tikanga guidelines to provide culturally responsive Health and Disability Services to Maori are sighted in both nurses’ stations.</p> <p>One of one Maori resident at Mt Victoria Lifecare,has a comprehensive plan of care documented that supports his cultural needs, as verified by file review and resident</p>

interview.

Staff receive annual education in relation to cultural safety and the Treaty of Waitangi.

The requirements of the ARRC 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.

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

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

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

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

**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.

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

**Standard 1.1.6: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Mt Victoria Lifecare provides an environment that enables residents to receive culturally safe services which recognise and respect individual ethnic, cultural and spiritual values and beliefs.</p> <p>Included as part of the admission and ongoing assessment process, residents and / or family / whanau are consulted about individual values and beliefs. Any special cultural, spiritual, values and beliefs requirements needed are identified and documented to inform the care planning and activity planning process to ensure those residents' specific needs and objectives are met.</p> <p>Staff receive yearly in-service training on cultural safety and the Treaty of Waitangi.</p> <p>Evidence to support findings is sighted in resident file reviews and staff training records. Resident and family / whanau interviews confirm staff implement cares to meet their needs and that Mt Vic Lifecare provides culturally safe services that recognises and respects their ethnic, cultural and spiritual beliefs and values.</p> <p>The ARRC requirements are met.</p>

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

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

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

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

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

ARHSS D16.5e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Mt Victoria Lifecare provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.</p> <p>Orientation / induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct and inform staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements. The manager will action formal disciplinary procedure if there is an employee breach of conduct.</p> <p>Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date as verified in staff, resident and family interviews.</p> <p>There is a policy on Ethics which states staff is expected to follow the National Standards of Ethics committee guidelines.</p> <p>The ARRC requirements are met.</p>

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

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

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

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

Consumers receive services of an appropriate standard.

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Mt Victoria Lifecare provides an environment that encourages good practice. All policies sighted are up to date, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales, which are monitored and evaluated at organisational and facility level.</p> <p>Human resources are managed to employ competent employees. New employees complete a comprehensive orientation/induction programme that is relevant to the role being undertaken. Staff records evidence competent employment practices, orientation and training records. The service supports and encourages staff with appropriate on-going education relevant to the role they undertake. The service has an extensive and diverse in-service education programme in place which is monitored at organisational level to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. Staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner.</p> <p>Incident reporting systems are evidenced to be linked to open disclosure and quality improvement processes.</p> <p>All care staff has or is undertaking the Aged Care Education programme and dementia training. Registered nurses who administer and/or check medication have yearly assessments to determine competency (sighted). Senior care staff has yearly competencies to enable them to 'check' accuracy of medication for the RNs where the medication is to be checked for accuracy by two persons (sighted).</p> <p>Registered nurses (RNs) have an up to date first aid certificates (sighted). Ongoing education for RNs is supported by the facility, the District Health Board, the specialist</p>

services that they operate and the local Hospice services. Kitchen staff have qualifications in safe food handling

Residents and relatives interviewed verify satisfaction with the services provided and resident satisfaction surveys undertaken annually indicates overall satisfaction with the service.

An interview with the GP, verifies satisfaction with the services provided. The service responds promptly and correctly to requests and is prompt in requesting input if needed.

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Mt Victoria Life care provides an environment conducive to effective communication.

Communication with relatives is documented in the communication sheet which is kept in the resident's file, and sighted incident and accident forms evidence resident and / or family are informed of incidents, when requested.

The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is

provided at orientation (records sighted). Staff confirm they understand that relatives and residents must be informed of any changes in care provision.

There are no residents that require interpreting services; however, management staff are aware of how to access interpreters if this service should be required.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

At the pre-admission meeting and admission the resident and their family / whanau are given information and a discussion is held to clarify what they wish to be informed about and at what time of day they wish to be notified (documentation sighted). Residents and family interviews confirm communication with staff is open and effective, that they are always consulted and informed of any untoward event or change in care provision, and are kept well informed (sighted in files reviewed).

The ARRC 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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Mt Victoria Lifecare provides residents and where appropriate their family / whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service. Residents are able to choose their GP of choice. The Facility Manager discusses information on informed consent with the resident and family / whanau at a preadmission meeting. Consents requests the resident's agreement to collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organised by the facility in addition to other consents relating to blood tests. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process. Files reviewed evidence informed consent forms signed on admission and identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. Medicine charts have residents' photographs for identification. Residents' choices and decisions are recorded and acted on.

An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non-consent to be revoked at any time. Advance directives are sighted in files reviewed. Verbal consent is obtained prior to an intervention being carried out as observed and verified by clinical staff, residents and family interviews. Care plans are signed by the resident and / or family / whanau, where appropriate, to say they have read and agree with what is written.

Staff education on consent takes place during orientation. Staff have an understanding of the informed consent process and confirm their understanding of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. The environment is observed to be one where choices are offered and openly acknowledged.

Resident and family interviews confirm they are provided with the necessary information to make informed choices, choices are respected by staff and staff confirm they respect the resident's right to decline refuse consent at any time. The consumer satisfaction survey results, sighted, indicate family / whanau satisfaction with involvement in care.

The ARRC 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.

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

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

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

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

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

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

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

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

**Standard 1.1.11: 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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Mt Victoria Lifecare recognises and facilitates the right of residents to advocacy / support persons of their choice. The Resident Rights Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during the pre-admission and admission process. They are instructed on their right to contact the Health and Disability Commissioner's office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility and is included in the admission information.</p> <p>The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally.</p> <p>The residents' advocate (a Salvation Army Minister), whom the residents are able to use for advocacy services if they wish, runs the monthly residents' meetings and during interview she states 'residents are very forthright in coming forward and management is very responsive' when she addresses the residents' concerns with them. Residents and their families are aware of their right to have support persons, as verified in clinical staff, residents and family interviews.</p> <p>The ARRC requirements are met.</p>

**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.

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

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Mt Victoria Lifecare provides an environment whereby residents are able to maintain links with family / whanau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family / whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges values and encourages the involvement of families / whanau in the provision of care and the activities programme actively supports community involvement and accesses community resources.

Resident and family interviews confirm that visitors can visit freely and there is free access to community services. It is observed that there were visitors coming and going from the facility during the audit. File reviews, the Facility Manager and registered nurses confirm community services used by the facility include:

- local social groups,
- the local community centre activities
- other aged care facilities
- local church groups and services
- the CCDHB nurse specialists
- The local needs assessment and service coordination agency (NASC)
- the service has a podiatrist who visits regularly
- residents have the GP of their choice
- CCDHB outpatient and inpatient services as appropriate.

The ARRC requirements are met

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Document review: There is a complaint / concern policy and associated forms. All residents are given a copy of the complaint form on admission and forms are available in all the facilities at all times. Facility managers are responsible for investigating and managing complaints. All complaints are recorded in the complaint register. The complaint / concern policy meets most of the requirements of Right 10 of the Code. However, after the initial acknowledgement being made within 5 working days the policy then goes to communication with a full response within 20 working days. Right 10 requires that after the acknowledgement is given the complainant is communicated within 10 working days and from then on every 20 working days (until resolution). This requirement is however being met and this is confirmed on day of audit in all six of eighteen complaint / concerns documentation reviewed.

The complaint register is sighted and there have been 18 complaints and concerns received so far in the 2014 year. All required timeframes have been met and in most of the six files reviewed have been exceeded. The issues raised are low level with no serious complaints being lodged. All files reviewed follow the process as per the organisational policy. A risk rating is applied to each complaint/concern and a risk matrix has been developed to guide staff. Any of a serious nature are immediately notified to the quality and audit manager who then provides support to ensure the process is followed and support given as required. Every complaint is then entered into the electronic quality system (GOSH) and becomes a part of the quality process.

The manager in interview confirms all complaints/concerns are responded to in writing within the required timeframes and if possible a written response is provided within 48 hours. An investigation is undertaken as required and updates are completed every ten days until resolution and sign off. Corrective actions are initiated as appropriate. The register has full paper documentation with all relevant actions and timeframes completed.

Two of two caregivers interviewed confirm a sound understanding of the complaint process and when formal action is required.

ARC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

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

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

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

## Outcome 1.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The facility is owned by the Spencer Family Trust which trades under the Ultimate Care Group name. It has a CEO and six national managers to provide relevant support to each of the 16 facilities in the group. Each facility has its own business plan which is written by the manager of the facility and approved by the regional operational manager. The vision and goals of the organisation are on display at the main entrance and these are integrated into the planning for each facility. A comprehensive suite of planning documents is sighted with a focus on quality aged care provision. These form a basis for the facility business plan which details the planned goals and actions for the current year with the manager completing weekly reports to the regional operational manager with whom weekly meetings are also held. The manager regularly updates the 'Outcomes measured against goals and objectives' report and this is reviewed by both the regional manager and the ACM.

The manager has been in the role for five months. She is a qualified RN who also holds a Bachelors degree in Commerce and Administration, Management and Commercial Law. The manager has had significant management experience and was in a management role at another aged care facility for three years prior to her appointment to Mt Victoria Lifecare. The support from the national office is evidenced on the day of audit with the ACM and the regional manager both reporting a close working relationship with the manager.

ARRC 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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The manager has not yet taken leave from her position but is planning some leave in July. Her role will be managed in her absence by the clinical services manager (CSM) who is available to step in as required. The CSM is not rostered on to provide direct care so is available to take over during any absences by the manager.

Both the CSM and the manager have management experience in the aged care sector with both maintaining RN registration. The CSM oversees all clinical roles and the laundry, cleaning, maintenance and kitchen staff are overseen by the manager, with a range of other staff taking leadership roles in all these areas.

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

There is a detailed quality and risk management plan which is reviewed annually. The current plan is 2013 – 2014. The organisation's quality policy states they will provide 'service excellence without compromise' through all levels of our organisation. The plan details the responsibilities for quality in each facility, specifically the facility manager and the senior clinical staff. The manager and clinical services manager will run the quality improvement programme in each facility. Feedback from residents / family/whanau and staff will be invited regularly throughout the year. There is a quality governance group which includes consultation with the regional operations manager and each facility manager. The QGG is made up of the executive team, audit & compliance manager, HR manager, project manager and the southern and northern operations managers. They meet six weekly and all managers receive updates and any changes to policies are sent.

A range of quality indicators will be monitored in 2013-14, these include clinical indicators (assessments, falls, pressure ulcers, skin wounds, bruises, behavioural incidents, infections, drug errors, near misses / incidents / accidents, weight loss and sentinel events) as well as non-clinical indicators (complaints, property/security / emergency incidents, staff injuries, in-service training and attendance, staff appraisals, induction and orientation of new staff, entry and exit numbers, agency hours).

Appendix A in the Quality and Risk management plan includes terms of reference for the following committees: restraint approval; quality; health & safety; resident care review; resident and family; staff meetings; registered nurse meetings; quality governance team and clinical advisory group.

There is a quality improvement plan that includes an annual calendar of internal audit activity and the month when each audit is completed, including monitoring of the activities programme, administration functions, human resources, health and safety, infection control, medication, resident care, Releasing time to care, quality, and maori health.

The ACM reports it is the intention to involve facility managers in six weekly meetings with invitations going to relevant managers on specific issues.

The minutes of the 27 May 2014 facility's quality committee, which comprises of the facility manager, CSM, infection prevention officer, restraint coordinator, kitchen and administration staff are sighted. These record the discussions held including any adverse events, staff training, restraint, internal audit programme and also presents incident statistics for the past month. These meetings are held monthly and minutes are made available to all staff.

The monthly staff meetings are also the opportunity to ensure staff are kept informed of activity in the facility and the wider organisation. The minutes of the 14 April 2014 meeting are sighted and the discussions involved reports from management, administration, hazard update, education and training, laundry bag changes, cleaning update, staff changes and activity programmes.

Residents also have bi-monthly meetings and concerns are addressed following these. The manager reports around a third of residents are usually in attendance. A recent action was to increase the lift maintenance programme to three monthly to avoid any problems occurring. Resident satisfaction surveys are completed annually and the results analysed. The analysis of the previous years survey are seen and these have informed the business plan.

A comprehensive internal audit programme is in place. Results from the cleaning, pain management, oxygen equipment, uniform standards, medication charts, challenging behaviours and personal care and hygiene are sighted as completed with appropriate corrective actions implemented and monitored for the issues identified.

These are also reviewed by the quality committee at their regular meetings.

A document control programme is managed by the ACM and policies are reviewed two yearly, unless a need is identified for an earlier review. These are now in the two yearly cycle of review, as the last ones were reviewed in 2012. A review of all on site manuals was completed in April and these are updated in line with both organisational and facility changes.

The quality management system is populated with data from the facility and reports are able to be generated in specific areas. One report is sighted for the incidence of falls at the facility in the past month. Comparisons with previous months, and all data entered into the GOSH system, is able to be followed through to each individual incident with all the information available. Colour codes are used to distinguish care levels. Incidents are entered into the on line system and these are reviewed at head office with high risk incidents being immediately alerted to the ACM. A trend analysis is available at national or facility level with corrective actions developed by the ACM as needed.

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Within the quality management system folder there is a detailed national policy on incident management and reporting. This states that all staff are responsible for reporting and responding to incidents and the place of analysis of incident data to assist in learning from them. There is a process for escalating serious harm incidents to head office and the senior manager (audit and compliance manager).

In the health and safety policies and procedures there is a guidelines document for reporting incidents / accidents. There is monthly analysis of incident / accident reports and individual events are to be followed up by the staff nurse on duty daily. The policy on incident / accident reporting states that each facility will ensure that the quality committee analyses collated data and that any serious incidents / accidents are reported to head office. There are a range of other documents (policies, procedures and guidelines) to assist staff in investigating incidents and accidents and taking appropriate action.

The UCG template quality plan includes the clinical and non-clinical indicators which are monitored and these include a range of incidents and accidents, including falls, skin tears and bruises, a range of infections (eg, skin, respiratory, urinary tract infections (UTIs)), incidents and accidents, near misses, serious and sentinel events. Non-clinical indicators include complaints, staff injuries and accidents, staff training, completion of appraisals, property / security or emergency incidents. In the infection control suite of policies there is a notifiable diseases policy which describes those diseases which are notifiable and the process to be followed for reporting them.

The incident reporting process is observed with an incident documented on the paper form then entered into the GOSH system to become a part of the monthly quality management cycle. The form includes documenting notification of family and medical professional as required. A copy is also filed onto the resident's notes. All incidents are reported to the manager who becomes involved as necessary. All incidents are then discussed at the monthly quality meetings.

The manager confirms there is regional public health approved equipment on site for all cases that require isolation and the process for notification to authorities is clearly understood. These are located on both levels of the facility.

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
In the policies provided there are three human resource policies: procedures for managers dealing with harassment; policy on implementing procedures; and allocation of staff duty rosters. There are two forms, a staff register and a file note form. There is another folder – Staff & Education – which has a range of documents covering staff recruitment, orientation and on-going education. There is a policy on police vetting which states that all new staff will have a police check prior to commencement of employment. Staff members working within a professional scope of practice will have their qualifications verified to ensure there are no restrictions on their scope of practice.
All recruitment is currently managed by the manager, with support from the CSM for all clinical appointments. The manager reports that when a vacancy occurs, head

office manage the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done internally by the facility. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed. The GP and the dietitian's relevant qualifications are sighted. All APCs are current and securely filed.

Seven of seven staff files reviewed have all the required documentation including police checks, reference checks, job descriptions, individual employment contracts, CVs, orientation sheets and current performance appraisals. Also included are training records for all individuals.

All new staff receive a comprehensive orientation. An initial session is held with the CSM who covers the introduction to the facility and gives new staff an orientation pack. This has a checklist of all activity required to be completed by the person and is expected to be completed within the first two months. New staff are then paired up with a more experienced staff member for at least three days duties. A review is completed, then as they are able to perform duties, they are given more responsibilities. Before the end of the three month trial period a report is given to the manager with a recommendation around full employment. All staff interviewed confirm the orientation was completed and they felt competent to carry out their duties as required.

A comprehensive training programme is in place. A large spreadsheet detailing all the training completed by each staff member is sighted. It also has details of upcoming training sessions for the first six month period of 2014. The CSM also reports she keeps individual attendance records. The CSM is responsible for the training programme and facilitates outside presenters as needed. Age Concern had completed their annual consumer rights session in April with 14 staff in attendance. The challenging behaviour session has been completed by all except three new staff in either February or May. All staff are required to attend training sessions directly associated with their role and as well as full staff attendance at emergency evacuations training. Eight staff attended a tikanga training session in May.

Ecolab conduct regular training sessions for all staff on handling of chemicals and waste products. People unable to attend particular sessions will have one on one training or another opportunity in the next planning cycle. Staff interviews (13 of 13) all report the training programme is relevant and they attend as required. They also confirm management are very encouraging to staff to upskill themselves with one caregiver about to obtain her RN qualification. The files reviewed (seven of seven) all have significant training recorded as being completed.

ARRC 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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Standard 1.2.8: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a policy / guideline document in the HR policies sighted entitled 'Allocation of staff duty rosters'. This describes the process for developing rosters in each facility which provides for 'staff designations and hours will be set according to the needs of the client groups, individuals and numbers. This will take into consideration the age, gender, safety, response times, ethnic requirements, cultural mix and equipment availability (i.e. hoists and hydraulic beds). Staff hours will be set to ensure that they are sufficient to provide safe care in a timely manner. This will take into account the dependency levels (NASC Assessments), time required to provide care according to the individual's lifestyle plans, infection surveillance results, incident/accident results including medication errors, staff injury and internal audit results.'</p> <p>Clinical rosters are maintained by the clinical services manager and are prepared fortnightly, in advance. Others are done by the manager monthly in advance.</p> <p>The rosters are sighted for the current week of the audit and the month. The manager reports the use of agency staff is decreasing with any absences being able to be covered internally. A new part time RN position is planned to assist with this.</p> <p>Two RN team leaders are rostered on each of the morning and afternoon shifts with one on duty overnight. They all hold current first aid certificates. A number of caregivers and other staff also have first aid qualifications. There are seven caregivers rostered on for the morningshift with four for the afternoon shift and three overnight.</p> <p>The majority of the RN staff are very experienced in this facility and the CSM, who has been in the role for eleven months, has significant experience in the aged care sector. The high skill level of the manager, who is also relatively new to the position, is evident in interview.</p>

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Negligible

**Evidence:**

Residents admitted to Mt Victoria Lifecare have the information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission (files reviewed). The service is not responsible for NHI numbers. The service receives referral information from Capital Support (local NASC) which includes relevant assessment and medical information. This information is used to develop individual resident's files. The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.

All records sighted are secure. Residents' current files are stored in key pad locked offices. The administrator keeps a register of past and present residents which includes details of name, NHI, DOB, GP and room number plus admission date and address, NOK and date left service (including discharge address) and/or deceased. Archived files are in a locked room, however currently there is no management system for records which are archived on site. This is an area requiring corrective action. The new administrator is an archivist and has commenced organising the files to ensure that all archived records can be easily retrieved.

All relevant ARRC 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.

<b>Attainment and Risk:</b> PA Negligible
<b>Evidence:</b> Archived records are stored onsite in a secure locked room but the records are in disarray and there is no evidence of an appropriate management system.
<b>Finding:</b> Currently there is no management system for records which are archived on site.
<b>Corrective Action:</b> Provide evidence of an appropriate system to manage archived records.
<b>Timeframe (days):</b> 180 (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.

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

**Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Mt Victoria Lifecare provides an environment whereby when the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Information provided includes full details of the services provided, its location, hours, how the service is accessed and identifies the process if a resident requires

a change in the care provided. Prior to entry, the resident must be assessed by Capital Support, the Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure the residents requires the care provided, and assessed by the Facility Manager to ensure Mt Victoria Lifecare is able to provide the services the prospective resident requires.

If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency. All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents. Prospective residents / family / whanau are encouraged to tour the site and make time for discussion with the Facility Manager or RN.

Nine of nine files reviewed (five of five hospital and four of four rest home) contain completed assessments by the NASC agency verifying placement is required. Admission agreements are signed and sighted and meet contractual requirements. Resident and family members interviewed confirm they were informed and involved in this process.

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

Mt Victoria Lifecare has a clear process for declining entry to a resident if they are unable to provide services the resident requires, and informing residents, their family /

whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. If appropriate an initial contact is made on behalf of the resident / family. The reason for declining entry are documented and kept on file.

The admission agreement (sighted), describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility.

The ARRC 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.

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Each stage of the service provision at Mt Victoria Lifecare is undertaken by a suitably qualified provider and is developed with the resident and their family / whanau.  Prior to admission to Mt Victoria Lifecare, a preadmission meeting occurs with the Facility Manager, the resident and family / whanau to attend to non-clinical formalities, such as providing the necessary information and documentation so all parties are fully informed, getting consents signed, EPOA in place, admission agreements signed and financial arrangements in place. The admission process is then a clinical nursing process, with all the formalities having been dealt with.

Within 24 hours of admission the initial assessment process is undertaken by the Registered Nurse (RN) and includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the resident's immediate needs. A medical assessment is conducted by the GP within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.

Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the resident's need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care, and the RN (where RN input is required) each shift.

The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every three months, or as needs change, to ensure the appropriate care is provided and the residents' desired outcomes are being met. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident's medication is reviewed three monthly, or as needs change, and this is conducted by the GP. Family contact is documented in the family contact record.

Evidence of the assessment process is sighted in five of five hospital and four of four rest home files (files) reviewed and verified by interview with two of two hospital residents, four of four rest home residents (residents), two of two hospital residents family / whanau, and two of two rest home residents family / whanau (family). Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the resident's care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have qualifications in food safety training (sighted). The contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Each RN oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice. A verbal handover by the RN occurs at the beginning of each shift to ensure all staff are familiar with the residents' needs. Residents have allocated caregivers to attend to their needs under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in residents' files, where specialist input is required.

The ARRC contract requirements are met.

Tracer 1 – Hospital Resident

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

Tracer 2 – Rest Home Resident

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Within 24 hours of admission to Mt Victoria Lifecare residents have their needs identified through a variety of information sources that includes the NASC assessment, other service providers involved with the resident, the resident, family / whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom with the resident and / or family / whanau present if requested.</p> <p>Over the next three weeks, the RN undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care and activity planning. The assessments are reviewed three monthly as needs, outcomes and goals of the resident change.</p> <p>Evidence of this is sighted in files reviewed. Resident and family interviews verify they are included and informed of all assessment updates and changes. Staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.</p> <p>The ARRC requirements are met.</p>

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

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

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

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The care plan is developed in consultation with the resident and / or family / whanau, documents the resident's individual plan of care identified by initial and on-going individual assessments, and describes the required support to enable the resident to meet their needs, goals and desired outcome. Residents have one set of clinical notes in which all providers involved with the resident's care document the resident's progress.

Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan.

Care plans are evaluated three monthly or more frequent as the resident's condition dictates. Short term care plans, document the existence of short term problems and the required intervention. Information from the assessment process informs the allied services of resident need. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer of interventions required in the activities programme, the physiotherapist is informed of any need for physiotherapy input and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed. Resident and family interviews verify they are included in the planning of their care.

The staff education records sighted demonstrate that staff receive appropriate training. Training records evidence education that includes code of conduct, infection control, code of rights, tikanga, privacy, restraint minimisation and safe practice, elder abuse and neglect and management of challenging behaviour. Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. Timely access to other health providers is evident in two of the residents' files reviewed, where specialist input is required.

The ARRC 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.

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The care and services at Mt Victoria Lifecare are delivered in a safe and respectful manner.

The provision of care is consistent with the desired outcomes in residents' files reviewed which document the residents' physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.

Interviews with residents and family / whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility. There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted).

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The present activities coordinator at Mt Victoria Lifecare commenced the role six weeks prior to the audit to cover until a new coordinator commences in three weeks. At this time there will be two activities coordinators (one full time and one part time) who will provide services to the residents. The present activities coordinator is not a trained diversional therapist but interview and records verifies previous experience in the role (sighted).

On admission, residents are assessed to ascertain their needs and appropriate activity requirements, as evidenced in files reviewed. The activities assessments and plans include the resident's preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the resident's response to the activities, level of interest and participation recorded. The goals are developed with the resident, and their family, where appropriate.

The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data. Activities reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, visits to the local places of interest, church services and home visits). Family / whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

A resident's meeting run by the residents' advocate or the manager is held every two months, and meeting minutes evidence that the activities programme is discussed. The yearly resident / relative satisfaction survey also captures feedback on the activities programme. Residents and family interviews verify satisfaction with the activities offered. The activities co-ordinator interviewed reports feedback is sought from residents during and after activities.

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Evaluation of residents' care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested.

Formal care plan evaluations are conducted by the RN at least three monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews verify they are included and informed of all care plan updates and changes.

The ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Standard 1.3.9: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Resident support for access or referral to other health and/or disability service providers is facilitated to meet the resident's need. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the Capital Coast District Health Board (CCDHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, though where possible a family member accompanies the resident. The facility has access to a van that can escort residents to appointments.</p> <p>Residents are given a choice of GP when they are admitted. Most residents use the services contracted GP. She visits weekly and offers a 24 hour/seven day a week service.</p> <p>Acute / urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed.</p> <p>The ARRC requirements are met</p>

**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.

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

**Standard 1.3.10: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner that keeps the resident family / whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person / facility responsible for the ongoing management of the resident. There is a specific transfer / discharge form that records all the relative information needed when transferring a resident. If the resident is transferring to CCDHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes.</p> <p>The ARRC requirements are met</p>

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>The Medication Management Policy is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.</p> <p>Medicines for residents are received from the pharmacy in the Robotic delivery system. A safe system for medicine management is observed on the day of audit. All RNs who administer medicines have current medication competencies (sighted). The RNs observed demonstrate good knowledge and have a clear understanding of the roles and responsibilities related to each stage of medicine management. Senior caregivers have competency assessments to ensure competency to “check” the accuracy of medicines when an RN needs a second person to check accuracy and another RN is not available. The clinical manager monitors to ensure all staff who administer medications have current competencies.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences twice weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The medicine prescription is signed individually by the GP. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities are recorded on the medicine charts (as sighted in 10 of 10 hospital and eight of eight rest home medication charts reviewed). Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.</p>

There is one resident who self-administers an inhaler at the time of audit. The sighted assessments for self-administration are in the file reviewed and meet the facility's policy.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in the files reviewed.

Standing orders are not used at Mt Victoria Lifecare.

The ARRC 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.

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

**Criterion 1.3.12.3 (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.

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are a range of food services audit tools which monitor aspects of the food services within each facility. These include: food services general, food handling techniques, effectiveness of dishwasher, equipment maintenance, food services, food temperatures, personal hygiene audits.

The food, fluid and nutritional requirements of the residents at Mt Victoria Life care are provided in line with recognised nutritional guidelines for older people as verified by the dieticians documented assessment of the planned menu, that changes seasonally (sighted). The kitchen has a current hygiene certificate issued by the Wellington City Council (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety. An external contractor monitors chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A kitchen cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements (cooked meat, chicken or fish and fresh fruit 100gm/ day). A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs is sighted.

Evidence of resident satisfaction with meals is verified by resident and family / whanau interviews and in sighted satisfaction surveys and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed (sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience.

Food is ordered by the cook on a weekly basis. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked food temperatures are monitored daily. Records sighted verify records are within accepted parameters. Raw meat is stored at the bottom of the chiller in plastic containers and is completely thawed before cooking. Any leftovers are covered and labelled with the date / time / contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a 'chemicals / hazardous substances' protocol which provides a number of instructions around handling chemicals, storage of chemicals / hazardous substances and procedure to be followed after chemical / hazardous substance spill. There are references to chemicals and cleaning products provided by Ecolab and material safety data sheets for their use.

Within the infection control documentation is a waste management section which includes policy and procedures for waste (blood and bodily fluids) management and disposal. In the waste management policy staff are instructed to report any exposure to waste / substances or needle stick injuries using the incident / accident reporting procedures.

The door to the chemical and cleaning store is locked as is the door to the laundry where cleaning products are in use. The firm **Ecolab** are contracted to supply all chemicals and cleaning products with relevant training. In the cleaning store a notice detailing all chemicals in use and instructions for safe use and what to do if there is a spill is sighted. Cleaning products are all colour coded for ease of identification.

A training register reports in May 2014 nine clinical staff and one cleaner attended a training session. The cleaning supervisor and the person who manages the laundry for the facility were both able to detail process and procedures required for the safe use of any chemicals. The CSM demonstrated the process for the safe disposal of waste products and the colour coded waste disposal bags clearly marked.

Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved, the laundry and the cleaning stores. Staff are observed using these throughout the facility as appropriate during the audit. Large 'outbreak bins' are located on each of the two treatment rooms along with smaller ones for use in smaller incidents.

All incidents are reported and documented, then entered into the quality management system. Both clinical and non-clinical staff report they are clear about the process for incident reporting in this area.

ARRC 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.

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

**Criterion 1.4.1.6 (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.

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

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

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

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

**Attainment and Risk:** FA

### Evidence:

The building warrant of fitness (WOF) is sighted and is due for renewal on 12 June 2014. The process for that renewal is currently underway. There have been no new buildings since the previous audit. The building is purpose built with wide passage ways and flat even surfaces with a large lift between the floors. The passage way is clear of any clutter and residents are observed moving freely with walkers and wheelchairs. Residents occupy two levels, with ramped outside access between them to enable residents to use all outside areas. These areas have well maintained gardens with trees, seating and shelter. Doors open out into the patio areas and enable easy access in fine weather. A small seating area at the main entrance was in use by a gentleman on the day of audit enjoying a pleasant afternoon in the sunshine.

ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

### Evidence:

### Finding:

### Corrective Action:

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

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

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

**Attainment and Risk:** FA

### Evidence:

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Level two has 18 residents and they have three showers and three toilets available. Level three has 17 residents in one wing with two showers and three toilets with 12 residents in the other wing also having access to three toilets and two showers. These are all spacious, hygienic and well maintained with privacy locks on all doors to ensure privacy. Visitor and staff toilets are available on both levels. All toilets and showers are well labelled with some having pictorial labelling as well. They also have a slide vacant / busy sign to assist with privacy.</p> <p>The hot water temperatures are checked three monthly with six monthly audits completed. These records are current. Hand sanitizers are sighted in all areas of the facility including all communal areas, entrances, residents' rooms, hallways and staff areas. The manager has a hand sanitizer pump bottle in her office.</p>

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All the rooms in the facility are single rooms with a hand basin, armchair, dresser and any other personal belongings the resident has chosen to bring. The floors have lino, a single bed and are cleaned to a high standard and tidily presented. All rooms have the resident's name clearly displayed on the door with one resident also having in/out signage. Many residents have their own television. There is ample space for storage of personal mobility aids. The rooms are able to accommodate hoists if required and all transport areas are observed to be free of barriers to impede movement of residents who use aids. Doorways are wide and the lift is able to fit a bed if needed.

ARRC 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.

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

**Standard 1.4.5: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The level with the highest number of residents has two large dining/ lounge areas with distinctive areas for activities including watching large screen television away from the table and dining areas. The other level has a separate dining area and a large lounge. Seating plans for mealtimes have been developed in response to requests from residents. These rooms are warm with plenty of suitable seating and are observed to well used by residents. The furnishings are appropriate and well maintained. There is a whanau room on level one should additional privacy be required. All communal areas are clean and tidy.</p> <p>ARRC requirements are met.</p>

**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.

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

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the quality management / audit documents there are a selection of internal audit tools, under 'household' for cleanliness, cleanliness of rooms, cleaning services, infection control – management of waste and monitoring of fridge and freezer temperatures. Similarly there are three audit tools for laundry services: condition of linen; handling of linen and laundry cleanliness; and laundry services audit.

The laundry has the required doors for dirty and clean laundry with well-marked areas for management of this. The process is observed on the days of audit with the soiled laundry arriving in colour coded laundry bags to separate soiled, towels, linen and personal laundry. Any soiled laundry has been through the sluice room process prior to arrival at the laundry. The large washing machine is used to do the different laundry types separately with the automatic dispenser in use appropriately. A smaller washing machine is used for feeders. A large dryer is in action and the clean linen is stored a large room ready for relocation back to the storage rooms on each level. Residents' laundry is sorted into each resident's labelled basket once it has been washed and dried. The person managing the laundry is observed wearing protective clothing and is able to describe her process for ensuring safe and hygienic operation of the laundry. The area is clean and neatly kept with access by a lock pad.

Ecolab are responsible for all the laundry detergents and maintain the machines. The chemicals are all colour coded and well labelled. They are securely attached to the wall for safety but are easily accessed by staff as necessary.

Internal audits are done on a regular cycle to monitor effectiveness with results being used to ensure standards are maintained.

ARRC 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.

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

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

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

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

There are policies / procedures and guidelines for emergency planning, preparation and response. There is a civil defence plan template document which is drafted and requires each facility to enter in their own local information, (ie, telephone numbers and addresses for the civil defence centre and emergency response centre, where and how much emergency water is held on site, the location of fire suppression equipment in the facility, the evacuation plan and assembly point). There are disaster planning guides which direct the facility in their preparation for disasters and describe the procedures to be followed for fire evacuations and regular practices. There is a list of what supplies are to be in the emergency pack. The policy prescribes that emergency water supplies are to be a 2000 litre tank and to use water stored in water coolers in the facility.

Emergency evacuation procedures are located on both levels in hallways as well as in both nurses stations. This includes procedures for fire, earthquake, bomb threat, aggressive behaviour, cardiac arrest, storm and flooding. The fire evacuation drill is held six monthly with the last one completed on 5 May 2014. This was observed by the fire department. Civil defence supplies are on site for use in a civil defence emergency. The RNs for each level carry a key to the sprinkler rooms should activation be required.

Staff training for emergencies occurs regularly and orientation includes an emergency training module. The CSM reports regular prompting, meetings and staff notices are all used by the management to reinforce required procedures. All RNs have first aid certificates except for two newer appointees who have training scheduled.

The approved evacuation plan is sighted. This was completed in 1999.

In the event of a power failure the manager reports they have a backup generator they can access with the facility designated a priority. Heavy duty torches are situated in both nursing stations and treatment rooms. Glow sticks are also placed on walls in a number of areas. An emergency cell phone is charged daily in the administrators office.

All rooms are equipped with a call bell which rings throughout each floor and the nurses' station. These are also in all the bathroom and toilet areas as well as the communal spaces. Both the manager and CSM in interview report no concern have been raised in the past six months around response times. All bells were observed to be answered promptly during the audit.

A security firm is under contract to the facility and does two random checks at night. The doors are locked at 7 pm, windows are all checked by the afternood staff daily. Staff are instructed not to open the door if they have any concerns and police are to be called. Residents interviewed all felt safe in the facility.

There are a small number of residents who need extra support and any concerns are being well managed by staff who have all attended training on challenging behaviours. One resident is currently being reassessed for suitability for the service and another assessment has been requested. Staff are well supported by the community mental health team at the local CCDHB as necessary. The manager confirms she is aware of any triggers that may result in difficult behaviour and manages these accordingly. During audit all residents are observed to be calm, happy and well managed.

ARRC 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.

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility is spacious, light and well ventilated with opening windows in all areas. As the audit is conducted during winter the central heating is in action and the environment is warm and comfortable. There is an additional heat pump in the large lounge on level three as it was identified as an area where this was needed for the comfort of the residents. All rooms have adequate natural light and opening windows.

ARRC requirement is 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

---

### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Document review: The organisation has a suite of policies, procedures and forms in relation to the use of restraints and enablers. There is a definition of restraint which is consistent with these standards, as is the definition of an enabler. There is a flow chart to guide the decision making before any restraint is considered and a consent process for residents / family / whanau or EPOA. There are forms for; consent, application, approval group recommendations, monitoring and review. Each facility will have a restraint coordinator and a restraint approval group. The approval group must approve the use of any restraint for a resident before it is utilised with that person.

There is a restraint register which is to be maintained in each facility. This includes a 'key' for the purpose of the restraint; whether the person is at risk of falls, a risk to themselves or a risk to others.

Education is provided to all staff at orientation and includes reading the restraint and enabler policies and procedures, and watching a video on restraint minimisation and safe practice from the ACE education dementia series. There is a questionnaire for ancillary staff and caregivers / hospital staff. There is a competency assessment which is reviewed and assessed by the restraint coordinator of the facility. Two education sessions on restraint were held in February of this year with a total of 24 staff attending. An evaluation was undertaken which supported the outcomes training session. Nine RNs have completed training and 15 caregivers. All staff are expected to complete training. Training is done twice annually.

The restraint coordinator reports her vision for the facility is to have a restraint free environment and this vision underpins all her work in this area. A rigorous process is followed and the documentation reviewed supports this. She confirms she is "constantly looking for other options". Restraint is only implemented if there are no other options. The restraint register is well maintained with easily accessed files and information. The coordinator attended relevant training in March 2014 and she has

responsibility for staff training and overall supervision of all restraint processes. The GP reports in the last meeting of the restraint committee which was held on April 2014 that “staff attendance at training sessions is higher than previously, and there are fewer residents under restraint. Processes and procedures are good”. The GP is happy to continue as a part of the approval committee. This committee has membership of the GP, the coordinator, the CSM, a RN and a caregiver. It meets quarterly and the minutes are sighted. The coordinator completes a six monthly report with the completed report from 11 March 2014 reviewed. This confirms the use of bedside rails and lap belts only.

Restraint monitoring forms are in place and these are sighted as largely completed. The coordinator reports these are checked daily and any gaps in monitoring are dealt with immediately with the staff member concerned.

Six enablers are in use. These are in response to resident safety requests. Regular monitoring is undertaken and records of these are sighted as completed as required. All residents’ files with restraints in use reviewed (five of five) have consents forms completed and approval from the families and the GP. The facility process has been followed in all cases.

ARRC 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All the files reviewed (five of five) have clear records detailing the process in use for assessment, consent, approval and review. A monitoring form has been developed for daily monitoring. The restraint coordinator, who is a RN, manages this process. A detailed job description is in place. The signed GP approvals are filed with care plans detailing the type of restraint and the timeframes around use, monitoring, evaluation and review. The coordinator completes care plans specifically for residents with restraints in place. These are reviewed three monthly. An information folder is also kept for all staff to be informed about the use of restraints and policy and procedures for implementation. The importance of family involvement is acknowledged and is integral to any restraint approval. The coordinator is clear if a family feels a restraint is not appropriate for their family member, it is not used. Currently five residents have restraints in place – two lap belts and three bedside rails. Six enablers are in use. Residents with restraints in use have anything they need placed within reach and any other support as required is provided by staff. Two hourly monitoring is in place for residents with restraints and one hourly for those with enablers.

ARRC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The assessments sighted (five of five) are in line with policy and procedures that ensure all risks are documented and taken into consideration prior to approval and implementation. Outcomes desired are clearly documented in care plans. All alternatives are recorded to have been considered and all other options explored. The resident and their family are fully informed of all the relevant risks and on-going discussions are held with them to ensure the restraint use is still appropriate. Restraint is clearly identified in care plans in all restraints' files sighted and these have the required signatures. The GP plays a significant role in the assessment process with all relevant documentation completed.

ARRC requirement is met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The use of restraint for residents in the facility who require this intervention is observed to be implemented safely. Bedside rails and lap belts are the only restraints used at the facility and staff have received the required training. Care plans are developed for each resident and these are reviewed on a three monthly basis or if any change occurs that indicate a review is necessary. There have been no reported incidents involving injury in the previous six months up until the day of the audit day. Monitoring is completed on specific forms with staff signing off each one or two hourly monitoring of the resident. These are sighted in all files reviewed. The coordinator reports being particularly vigilant with staff to ensure these are done as required. The three monthly care plans provide for comprehensive review of the processes and outcomes achieved. One resident has had the use of a lap belt discontinued in the last month as it was no longer deemed as necessary. This was the result of successful de-escalation practice.

ARRC requirement is met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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

**Criterion 2.2.3.5 (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.

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

Evaluations of restraint are completed three monthly by the restraint committee or sooner if indicated. These are well documented on the residents' records and are sighted on five files reviewed. These are all signed by the GP and also include discussions with staff who are involved with the resident and the use of restraint. The procedures are followed and the documentation is clear and records easily accessed. Restraints in use currently are only to ensure the safety of the resident involved. Records are comprehensive with sufficient detail to reflect all policies and procedures are followed. Any changes to the use of the restraint following evaluation are noted on the restraint care plans.

ARRC requirement is met.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a six monthly report for the quality review of restraint use in each facility. The document 'guidelines for the safe and appropriate use of restraints and enablers' describes what will be discussed at the six monthly review meeting by the restraint approval group. This includes the amount of restraint use in the facility, whether alternatives to restraint are considered, the effectiveness of individual evaluation of restraint use, the competency of staff and the appropriateness of restraint / enabler education, and the progress towards a restraint free environment.

The restraint coordinator completes the six monthly review report and this is discussed by the approval group committee meeting. The last review completed on 11 March 2014 is sighted. This contains information on all current restraints and enablers in place at the facility as well as a trend analysis to inform future use and also to explore the use of all other options as required. Completed training is reported on as well as any training needs identified and progress made towards the restraint free environment the coordinator is aiming for. The GOSH system is also able to generate reports for both the facility and the larger organisation.

ARRC requirement is met.

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

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

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

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

## 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Mt Victoria Life care provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering

infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the infection control coordinator to ensure appropriate resources are available for the effective delivery of the infection control programme and it is her responsibility, assisted by the clinical nurse manager, to implement the programme.

The infection control practices are guided by the infection control manual and assistance from the CCDHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Reporting lines are clearly defined. The infection control coordinator records monthly infection rate data and presents a monthly report to the quality meeting and staff meetings. The manager reports to the organisation's quality manager. The infection control programme is reviewed annually.

### **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.

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

### **Criterion 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.

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

### Criterion 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.

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

### Standard 3.2: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The infection control coordinator is responsible for infection control at the facility. A position description is included in the infection control (IC) programme and in the RN's file.</p> <p>The infection control nurse verifies there are enough human, physical and information resources to implement the infection control programme. She takes responsibility for implementing the programme and has access to expert advice when required. Infection control training of the infection control nurse occurs via training offered through CCDHB.</p> <p>The infection control nurse has access to diagnostic records to ensure timely treatment and resolution of infections.</p> <p>The infection control nurse facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. The IC nurses report to the quality committee and staff meetings any IC issues on a monthly basis. IC data is collected monthly and statistics and data is calculated.</p>

### 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.

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

### Standard 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Mt Victoria Lifecare has an infection control (IC) programme that is reviewed annually and includes policies and procedures. These cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the manager as current.</p> <p>Staff interviewed (eight of eight clinical staff) are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry and kitchen staff (three of three) are observed to be compliant with generalised infection control practices. A new staff member in the process of orientation, verified training in infection control during orientation. A review of the Mt Victoria Lifecare's MRSA policy is at present underway with input from the infection control nurse at CCDHB</p>

### 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.

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

### Standard 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Staff receive orientation and ongoing education relevant to their practice as verified by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation. Resident education occurs in a manner that recognises the resident's cognitive ability and meets the resident's and the families / whanau's communication style. A resident with a cough is observed to be non-compliant with requests to remain in his room, but is happy to comply with requests to use tissues.  There has been no evidence of Norovirus since 2012.

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

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

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

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

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

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

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  <p>In line with Mt Victoria Lifecare’s IC policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form, fed into a database and graphed. Incidents of infections are sighted and are low. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a quality meeting every month and a staff meeting every month where the incidents of infection are presented. A yearly comparison based on previous incidents is used as a comparison if required. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed.</p>

**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.

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

**Criterion 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.

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