# Pinehaven Cottage Limited

## Current Status: 5 June 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Provisional 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

Pinehaven Lodge provides rest home level of care for up to seventeen residents. On the day of the audit there were fifteen residents residing at the home. The nurse manager has been in her role for nine years and continues to implement systems relating to policies and procedures to ensure compliance with certification requirements.

This provisional audit is undertaken to determine the suitability of the prospective provider. The new provider owns and operates another aged care facility and is aware of the requirements.

There is one area requiring improvement, relating to medication management. All other requirements of the audit are met.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Pinehaven Cottage Limited |
| **Certificate name:** | Pinehaven Cottage Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Provisional Audit | | | |
| **Premises audited:** | Pinehaven Cottage | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 5 June 2014 | **End date:** | 1 July 2014 |

**Proposed changes to current services (if any):**

The service is planning a sale and purchase agreement, therefore a provisional audit, that is based on a very recent certification audit, has been completed.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 15 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 10 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 6 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 24 | Total audit hours | 40 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 4 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 25 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, 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, 10 July 2014

## **Executive Summary of Audit**

**General Overview**

Pinehaven Lodge provides rest home level of care for up to seventeen residents. On the day of the audit there were fifteen residents residing at the home. The nurse manager has been in her role for nine years and continues to implement systems relating to policies and procedures to ensure compliance with certification requirements.

This provisional audit is undertaken by telephone interview with the potential new provider.

A certification audit had been completed less than one month prior to the provisional audit and the certification audit report has been used as the basis for this report. There is one area requiring improvement, relating to medication management. All other requirements of the audit are met.

**Outcome 1.1: Consumer Rights**

The service has processes in place that demonstrate their commitment to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.   
  
Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident’s independence and reflects the residents’ and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.   
  
Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural, values and beliefs are provided for at the service.   
  
Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice. There is a complaint process and register which complies with the required standard.  
  
Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff are demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

The new provider reports by telephone that she fully understands residents’ rights.

**Outcome 1.2: Organisational Management**

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The organisational governance systems for clinical care, staffing, operational and financial aspects of the service are monitored on a quarterly basis through the service’s clinical governance system.   
  
The service is managed by an appropriately experienced and qualified person/enrolled nurse (EN) who is responsible for the overall running of the service. There is also a registered nurse (RN) to provide additional clinical direction to the staff. The manager reports to the owner of the service directly.  
  
The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place, which is linked to the clinical governance monitoring and reporting system for the early identification of potential areas that can be improved. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There are sufficient policies and procedures which describe all aspects of service delivery and organisational management.

The resident’s files are integrated and kept in a secure place in the nurse’s and accessible for all health care providers.  
  
The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery to the rest home residents. Rosters sighted document an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board and standards for safe staffing in residential care. The education programme is available for all staff and education records document staff attendance.

The new purchaser reports by telephone that she understands all systems required for governance and quality systems.

**Outcome 1.3: Continuum of Service Delivery**

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for rest home level of care and a bed is available. If residents’ needs exceed rest home level of care, reassessment is conducted and the resident is transferred to a service that better meets their needs (eg, hospital level of care or secure dementia care).   
  
The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes. The evaluation of care is conducted at least six monthly, with this documenting the resident’s response to interventions and progress towards meeting goals.   
  
Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and co-ordinated to minimise risks.   
  
The service provides planned activities to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The service has links with community organisations for activities both onsite and offsite.   
  
The observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies. There is one area requiring improvement to ensure the checking of the controlled drugs register is consistently conducted weekly.   
  
Residents are provided with food, fluid and nutritional services that are reviewed as being suitable to meet the nutritional needs of the older person. Residents receive additional or modified nutritional requirements; special diets and food that takes into account the resident’s likes and dislikes.

**Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate for rest home level care. All areas ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, and is in a setting appropriate for the residents. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

All buildings, plant and equipment complies with legislation. The building has a current building warrant of fitness. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan to address the upkeep of the building.

The facility has an appropriate call system to request assistance from staff. Residents have access to external gardens and an internal courtyard. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Residents are provided with adequate toilets, showers and bathing facilities. There is a mix of ensuites and common facilities conveniently located throughout the service. Residents are assured of privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

The new owner has no immediate plans to make any environmental changes to the facility.

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

There is no restraint or enabler in use at this facility at the time of audit. The unit is designed to allow maximum freedom of movement while promoting the safety of residents. The policy describes the safe use of restraints with ongoing review, assessment and evaluation. The service demonstrates the continued quality review of their use of restraint if required.

**Outcome 3: Infection Prevention and Control**

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The service’s policies and procedures comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, and when relevant, residents and family/whānau.   
  
There is a monthly collection of surveillance data for infections. The surveillance data is collected, collated and analysed, with results communicated to staff. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. The service has clear procedures to deal with outbreaks.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 1 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | One of the controlled drugs sampled has a 15 day period between the stock count recordings. | Ensure the weekly stock count of the control drugs are consistently recorded at weekly intervals. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering residents’ bedrooms, use residents’ preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (four staff from across the care and kitchen services) confirm they respect the resident’s right to refuse cares or interventions. The interviews with four of four residents and three of three family/whānau members confirm they or their family member receives services that respect their rights. The residents and families commented that one of the strengths of the service is in the manner that all staff respect the residents as individuals. The general practitioner (GP) interviewed has no concerns about breaches of residents’ rights.   
  
The Age Related Residential Aged Care (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: The consumer rights policy outlines service requirements to meet resident rights within the facility.

Opportunities are provided for explanations, discussion, and clarification about the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) with the resident and family/whānau as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service are clearly displayed at the entrance to the facility and available to residents and visitors. Interviews with four of four residents and three of three family/whānau reports they are informed of their rights and that staff always respect all aspects of their rights.

The purchaser reports by telephone that she is aware of residents’ rights and the requirements to ensure they are fulfilled as they own another facility which complies with the same standards.  
  
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:**

Documentation Review: Policy identifies staff responsibilities related to privacy. There is policy covering resident’s safety and abuse prevention and security. This is detailed and identifies what staff should do if they suspect any issues. The residents' safety and abuse prevention policy provides appropriate definitions of abuse, describes signs of abuse and neglect, different staff roles and responsibilities and prevention strategies.

The environment allows residents’ physical, visual, auditory and personal privacy. All rooms are single occupancy to maintain privacy. Resident’s needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in four of four resident file reviews which identify interventions put in place match identified needs.   
  
As observed at the time of audit services are provided in a manner that maximises each resident’s independence and allows choices to be respected. The four of four residents and three of three family/whānau report that they are treated with respect and that resident’s receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: The service has cultural safety guidelines for staff to enhance their practice and approach to Maori residents and whanau. The service uses the four corner stones of Maori health to assess and deliver services (te taha tinana, te taha wairua, te taha hinengaro and te taha whenua). The importance of whanau is described as crucial to resident’s wellbeing and the service actively encourages, supports and includes whanau in all aspects of care and decision making. Policy states that resident’s cultural beliefs are ascertained upon admission via assessment and documented on the resident’s care plan.

Māori residents have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. The manager reports there are no barriers to Māori accessing the service. There are a number of Māori residents and staff at the service. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interviews with three care staff (one RN and two caregivers). Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. The file of a resident, who identifies as Māori, records the resident’s iwi and describes the importance of whanau. The resident has weekly outings with komatua and cultural advisors. The Māori resident’s file and advance care plan reviewed demonstrates the resident receive services commensurate with their needs for their planned care prior to and after death (confirmed at interview with care staff and the resident).

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: The cultural policy has the documented objective ‘to meet culture values and beliefs of our residents, their family and our staff’. There are general guidelines to assist staff in the assessment and delivery of services that will meet residents’ cultural and spiritual needs. This includes the use of interpreter services as required. Residents receive services that take into account their cultural and individual values and beliefs. On-going resident satisfaction surveys monitor this as part the information collected. Policy identifies that the resident's choice of representative is accepted by the service.  
  
Interviews with four of four residents and three of three family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care plan (as sighted in four of four resident file reviews).   
  
The ARRC requirements are met.

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

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Five staff record reviews identify that staff sign a code of conduct that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with four staff, four of four residents, one GP, and three family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interviews with the four staff (one RN, two caregivers and one cook) confirm that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. Interviews with four of four residents, three of three family/whānau and the GP confirm their high level of satisfaction with all care delivery and staff attitudes. This is further supported by the results of the recent resident satisfaction survey.   
   
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:**

Policy related to open disclosure is implemented by the service. Interviews with three of three family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family/whānau communication is clearly documented in the four of four residents’ files reviewed, on incident and accident forms sighted and in the staff communication book. The family/whānau, residents and GP interviewed report that communication is strength of the service.   
  
Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. At the time of audit there are no residents who require interpreter services.   
  
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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: Policy clearly describes that gaining consent for all actions is voluntarily and must be given without inducement, force, duress or coercions. It includes advance directives and living wills which can only be completed by the resident. Information in policy identifies the resident’s right to make an informed choice and give informed consent, the right to be fully informed and the right to effective communication.   
  
Signed consent forms are sighted in the four of four residents’ files reviewed. One resident’s file reviewed identifies the resident is under a compulsory treatment order. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with four of four residents and three of three family/whānau members. The four of four residents’ files reviewed have correctly signed advance directives or an advance care plan identifying the resident’s chosen wishes related to resuscitation status and end of life care. The three of three clinical staff (one RN and two caregivers) demonstrate their understanding of acting on valid advance directives.   
  
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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: Evidence is sighted in policies that the resident’s right to advocacy and the support person of their choice is recognised. The Residents’ Rights Policy identifies the consumer'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 their admission. 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.

The four of four residents’ files reviewed, interviews with four of four residents and three of three family/whānau confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family/whānau members confirm their awareness of where to locate the information.   
  
ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Interviews with four of four residents confirm they have access to visitors of their choice. The three of three family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.   
  
Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in four of four residents’ files identifies that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. One resident has weekly outings with a kaumatua. Some community outings include weekly coffee club group, shopping trips, regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended services in the community.   
  
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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation review, the complaints management policy, procedure and flow charts sighted comply with Right 10 of the Code.

The service has an up-to-date complaints register which identifies the date of the complaint and the actions taken and when resolved. The register also records if advocacy process is commenced. Complaints management is used to improve services as appropriate. The service has no ongoing external complaints since the last audit.

The four of four residents and three of three family/whanau interviews confirm they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. They state they would feel comfortable to make a complaint at any time. The information given to all residents and family/whanau upon admission includes complaints forms and a full explanation of how the system works. Advocacy information is also included in the admission booklet. Both the complaints and advocacy information is on full display at the entrances to the facility.

Interviews with three of three care staff confirm awareness of their responsibility to record and report any complaints they may receive.

##### **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:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation review: The business plan includes the decisions made in policy and budgeting. It identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. The quality policy statement identifies the mission of the organisation and the procedures undertaken to achieve the mission statement. Actions described include the use of quality programmes and procedures, identification of hazards, staff training and education, data reporting of incidents/accidents, infections and internal audit results to identify trends and improve services. The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. The goals are reviewed annually using the quality monitoring system.  
  
The service is managed by a facility manager who is an enrolled nurse (annual practising certificate sighted). The manager has over nine years of experience in the management of aged care services. The manager has a job description that describes authority, accountability, and responsibility for the provision of services (sighted). The manager has completed over 8 hours education in the previous 12 months related to the management of aged care. The manager completes a professional portfolio and maintains professional knowledge through ongoing education. This includes attendance at aged care conferences, local education available, first aid recertification and specific education related to aging processes and illness. The manager is support by a registered nurse (RN) and the owners.   
  
The four of four staff and GP report the service is managed very well. The owner interviewed has full confidence in the experience and skill of the both manager and RN to effectively perform their roles.

The purchaser reports by telephone interview she is comfortable with the requirements of an organisation to have an organisational plan and governance which complies with the HDSS.   
  
The new owners are experienced aged care providers and are planning to keep management processes the same during the transition phase.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During a temporary absence of the manager a suitably qualified RN is able to perform the manager’s role. The RN reports her job description includes taking on the role of manager during the manager’s temporary absence. The RN maintains a professional portfolio. She has been employed at Pinehaven a short time but has previously been in aged care management.

The purchaser reports by telephone that there is no plans at present to make any changes to the service and will retain all staff.

##### **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:**

Documentation review: The quality and risk plan identifies the process for risk identification, controls and on-going actions required to limit identified risks. Risk categories include consumer focus, provision of effective programmes, certification and contractual requirements, risk management, and continuous improvement. It identifies generalised goals and objectives and who is responsible and the measure used to identify how the controls are effective or responsive to residents’ needs.

Family and resident feedback is sought through satisfaction surveys to ensure satisfaction with the care provided. This includes meals, involvement with care and activities provided.  
  
The monitoring of the clinical, operational, financial and staffing risks is through an internal auditing system. There is a three monthly report which includes infection control, health and safety, hazards, restraint, complaints, staffing changes, care planning, environmental matters, equipment, maintenance, education, staff meeting outcomes and quality improvements. All information is taken to the staff meeting as identified in minutes sighted. All data is trended and trends are analysed by the management team and corrective action plans are developed as required. Results of trends and required corrective actions are discussed at the eight weekly staff meetings as confirmed by staff and management interviews and in minutes sighted.  
  
The quarterly quality management and eight weekly staff meetings monitor the services achievements against the organisation’s quality and risk management plan and reports progress to both the owners and at staff level. Required corrective actions are discussed and reviewed at all meetings, as confirmed in minutes sighted.   
  
Interviews with two of two caregivers and one RN confirm they are aware of quality systems and that they are informed of audit results at staff meetings. Staff confirm that open discussion occurs related to all quality and risk issues and those meetings are used to measure quality improvement outcomes (sighted in meeting minutes).   
  
Staff discussions, regular internal audits, quality and risk data evaluation and consumer surveys are used to indicate achievement measurements. Documentation identifies that areas for improvement as required and evaluated.  
  
The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for rest home level of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes. An interview with three of three clinical staff confirms their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards is set out in the information book given to all residents and family/whanau.  
  
There is a document control system to manage the policies and procedures. The policies are updated at least two yearly, or earlier if there are legislative changes. New and updated policies are displayed in the staff office and tabled at staff meetings. Staff only have access to current policies and procedures, with obsolete documents removed from staff access.   
  
Four of four residents and three of three family/whanau interviews confirm any issues that are raised are addressed promptly and that they are kept informed of the outcome. Satisfaction survey results confirm interview findings.

The purchaser reports by telephone interview she is familiar with the requirements of the HDSS relating to policy, procedures, quality plans, management systems and internal audits.

##### **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:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review Policy related to accidents and incidents states that all adverse, unplanned or untoward events are systematically recorded, investigated and analysed.

The staff and management interviewed understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The manager reports that there have been no serious incidents that have required essential notification.   
  
The service uses health and safety report forms to document adverse, unplanned or untoward events or near misses. The monthly reports of the incidents and accidents record the number of incidents and accidents. Shortfalls identify opportunities to improve service delivery and manage risk; this includes implementing strategies at the increased times of falls, for example. Results of incident and accident trend analysis are discussed at the staff and management meetings and reports are presented to the owners as appropriate (eg, if there is serious injury).   
  
An interview with two of two caregivers and the manager confirms their understanding of the need to document all adverse events.  
  
The four of four residents and three of three family/whanau member interviews, and documentation sighted on incident/accident forms in four of four residents’ files, confirms family/whanau are kept well informed of their relatives care requirements and are contacted appropriately by the service if there are any concerns.

The purchaser reports by telephone interview that they have knowledge of health and safety, employment and local body requirements. There are no legislative compliance issues identified that could affect the service.

##### **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:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: Human resources policies describe good employment practices that meets the requirements of legislation. Ongoing training is provided to ensure staff comply with health and Safety standards.

Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The manager ensures that staff who require practising certificates have them validated annually. Practising certificates are sighted for all staff who require them.  
  
Human resources practices are implemented as per policy requirements and four of four staff record reviews (one RN, two caregivers and one cook) identify that staff are employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate.

The service undertakes regular in-service staff education which identifies that guest speakers/educators along with the RN who presents education. (Content of education sighted). Staff confirm during interview that they have access to external education/training and this is highlighted in four of four staff file reviews. Each staff member has a clearly identified education attendance record. Staff appraisals are up-to-date and used as a method for staff to identify educational needs, wants and interests. Education sighted covers all key components of service delivery.

The four of four residents and three of three family/whanau interviews and the 2013 resident/relative satisfaction survey results sighted confirm services are delivered in a manner to meet required needs.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs and contractual requirements with the WDHB. The care staff rostering and skill mix is based on clinical indicators for safe staffing in aged care. The manager is onsite Monday to Friday and the RN three days per week.  
  
The GP interview confirms there is a system in place for after-hours medical services. Interviews with two of two caregivers (one who works morning and afternoon shifts) confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. This is supported by interviews undertaken with the four of four residents and three of three family/whanau members.

The purchaser reports by telephone interview that she has knowledge of staffing skill mix, contractual obligation and resident acuity. At the other facility owned by the purchaser the safe staffing level guide along with a practical approach is used.

##### **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:** FA

**Evidence:**

The four of four residents’ files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses’ station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member’s name and designation. The current progress notes are in a separate folder from the resident’s main file, although these files demonstrate integration of the records with the progress notes then filed in the main clinical folder. The four of four residents’ files reviewed evidence that all records pertaining to individual residents are integrated.

Evidence is seen in resident’s files of required data being obtained and kept confidential. This is easily identifiable and accessible for staff and other health care providers.  
The information is up to date and accessible as required. Files that are not current are stored in a locked room on the same property as the facility. All health care providers use the integrated file in the nurses’ station.

The ARRC requirements are met.

Evidence is seen in resident’s files of required data being obtained and kept confidential. This is easily identifiable and accessible for staff and other health care providers.  
The information is up to date and accessible as required. Files that are not current are stored in a locked room on the same property as the facility. All health care providers use the integrated file in the nurses’ station.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, their family/whānau of choice where appropriate, local communities, and referral agencies. The service offers rest home level of care. The service has a pre-entry form which identifies the residents required level of care. The vacancy and entry requirements are updated daily on the Eldernet website.   
  
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:**

When entry to the service has been declined, the potential resident and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services. The pre-entry form and discussion with the manager records the reason for declining, contact with the client/family and alternative options are discussed. The manager reports that where a resident has had an appropriate assessment and there is an available bed, no residents have been declined entry.   
  
The sighted admission agreement contains sections on the conditions in which the agreement can be terminated and changes to the level of care. The services will ensure that if they are no longer able to meet the needs of the resident (eg, require hospital level of care or secure dementia level of care) there will be an appropriate reassessment; the service will assist to find an alternative service provider and ensure the transfer occurs in an appropriate and timely manner.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage two: 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. The RNs are responsible for assessment, planning, provision, evaluation, review, and exit, with consultation with the caregivers, activities staff, and GP and family/whānau communication. The main provision of care is provided by caregivers. Annual practising certificates are sighted for all staff that require them. The GP expressed high praise for the clinical skill and judgement of the nursing staff. All residents and family/whanau express high satisfaction with the care and services provide at Pinehaven Lodge.   
  
The service has not yet commenced the electronic InterRAI assessment tool; training is planned for September 2014. 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. The service has assessment and care planning tools for wound care, pressure area risk, nutritional assessment, pain assessment, continence assessments, short term care plans, falls management and social and activities assessments. The care plans are based on the assessed needs of the resident. The sighted care plans in the four of four residents’ files reviewed identified personal, physical, psycho-social, spiritual and cultural needs of the resident.   
  
The four of four residents’ files evidence that the initial assessment and initial care plan are conducted on admission, with the long term care plan developed within three weeks of admission. The assessment and care plan are reviewed and updated at least six monthly. Where required the residents are reviewed by a GP within two working days of admission, then at least monthly or three monthly where assessed as stable.   
  
The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Each shift has a verbal handover and there is a written handover sheet which identifies care requirements including any required changes. Each shift there are entries into residents’ progress notes. The three of three care staff interviewed (one RNs and two caregivers) report they receive adequate information at hand over.   
  
Tracer example:

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

The ARRC requirements are met.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.3.4 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review The clinical management policy identifies residents’ needs are ascertained through the assessment process. This includes continence, hygiene and personal grooming, skin management and wound management.   
The needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for care planning and service delivery. The four of four residents’ files reviewed have assessment tools completed to develop the long term care plan and reassessment occurs at least six monthly, or earlier if there is a change in the residents’ needs. The service also utilises other appropriate assessment tools to assess resident’s needs. These include wound assessment, pressure risk, and nutrition and falls assessment.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The long term care plan and short term care plans sighted identify the supports and interventions to achieve desired outcomes, as confirmed in the four of four residents’ files reviewed. The resident reviewed using tracer methodology has a care plan and short term care plans that describe the required interventions for their palliative care. The four of four residents’ files reviewed identify that care planning is individualised to reflect resident’s assessed needs and interventions and support systems are clearly shown. Interventions are detailed and interviews with the three of three care staff (one RN and two caregivers) confirm the information ensures continuity of care. Interviews with four of four residents, three of three family/whānau and the GP report care is provided by staff that have excellent knowledge and skills.   
  
The four of four residents’ files reviewed demonstrate service integration. Residents have one main folder that contains their medical information, nursing assessment, care plan, routine observations, activities, therapies, multidisciplinary reviews and correspondence including off site consultations. The current progress notes are in a separate folder, and then placed into the resident’s main clinical file. There is integration within the progress notes and files, with input recorded from the care staff, GP, laboratory results, referrals and specialist consultation records. The electronic records (eg, care plan) are printed and a copy is maintained in the resident’s folder.   
  
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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The four of four care plans reviewed confirm care planning is individualised and personalised to be a true reflection of resident’s assessed needs. When required additional short term care plans or clinical pathways are utilised where there is a specialised need (eg, falls minimisation and end of life care). As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions.

Interviews with the two caregivers confirm they use documented interventions to provide appropriate care for each resident. If an intervention is not working well it is reported to the RN or manager who then evaluates the resident’s progress and resources current accepted best practice to assist in resolving any issues. The four of four residents and three of three family/whānau confirm they are highly satisfied with care and interventions provided by the service. Residents stated all their needs are met. Comments from residents include the service provides a much personalised service that respects their individual needs.   
  
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:**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. At the time of audit the role of activities coordinator is in the recruitment process, with the planned commenced of the activities coordinator in June 2014. The nursing and care staff are currently coordinating the activities (as observed at the time of audit). The group and individual activities are based on what the resident wants to do, with a strong emphasis on community activities and outings that reflect the interests of the residents. The four of four residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file six monthly. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. Residents are also observed at the time of audit to be engaging in independent activities, such as going out into the community, reading, listening to music and doing exercises. The four of four residents express satisfaction with the activities programme.  
  
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:**

Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans or clinical pathways. Short term care planning sighted for infections, falls minimisation, acute conditions and wound care as confirmed in the notes of the resident reviewed. The short term care plans document the interventions are analysed, reviewed, discussed with the resident and family/whānau and evaluated for achievement towards clearly set out goals. If the interventions are not working well they are changed and staff are informed. The four of four residents and three of three family/whānau interviews confirm that they have very high satisfaction with the care provided.

The four of four care plan evaluations sighted are documented, resident-focused; indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.   
  
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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Referrals are made to other medical services by the RN or GP as appropriate. Records of referrals are sighted in the four of four residents’ files reviewed. Health services accessed include general medicine, surgical services, cardiology, radiology, dietitian, mental health, ophthalmology, immunology and oncology. The GP confirms that appropriate referrals to other health and disability services are well managed at the service.  
  
ARRC requirements are met.

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

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

**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 1.3.10: 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

**Attainment and Risk:** FA

**Evidence:**

Risks are identified prior to planned discharges (confirmed by interview with the RN). There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family/whānau or resident want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision and intervention requirements and is sent with the resident as appropriate. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place.   
  
ARRC requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Documentation Review: The safe medicine management guidelines outline the most suitable procedures for ensuring the safety and efficacy of medicine use and describe minimum standards for storage and use of medicines. Policy states all medication is administered by the registered nurse or caregivers who have been competency tested. The policies and protocols cover all aspects of medicine management that complies with current legislative requirement and safe practice guidelines. This includes resident self-administration of medicines and standing orders. A medication management policy is documented and refers to the processes to be used to prescribe, dispense, administer, review, store, and dispose of medications.

The service implements the medicine management process according to the policy and procedures. A safe medicine administration system is observed at the time of audit (observed a caregiver administering the medicines). There is an area for improvement in the weekly checking of the controlled drugs (refer to criteria 1.3.12.1).   
  
The medicines are dispensed by the pharmacy in a pre-packed system. The packs are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines) are individually supplied for each resident. The medication packs and other non-packed medicines are checked for accuracy against the prescription by the RN when they are administered. The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly which he signs for on the resident medication chart. The GP conducts a review of the resident’s medicines at a minimum of three monthly which the GP signs for on the resident medication chart. At the time of audit, the service does not use standing orders.   
  
The medicines are stored in a locked cupboard in the staff office. The medicine fridge is monitored for temperature, with the weekly temperature recordings complying with guidelines. Sample signature verification is recorded for all staff who administers medicines.   
  
The number of medicine charts reviewed is increased from eight to 10 to further review the medicine signing sheets. One of the medicine signing sheets has one lunch time medication that is not signed as given, or if withheld, the reason not given. All other nine medicine signing sheets sighted are fully completed, with all medications signed for (though one medicine signing of medication is not documented, this is not a systemic issue). A review of 10 of 10 medicine charts identifies that each medication is signed for by the GP. All prescriptions are computer generated by the pharmacy and they allow a safe medication administration process to be undertaken by staff. The prescriptions are legible, record the name, does, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify resident allergies recorded.   
  
The RN and some designated caregivers are responsible for medicine administration at the service. All staff who administers medicines have a current medication competency.   
  
One of the medicines charts reviewed is of resident who self-administers some of the medicines (eg, supplements and alternate medicine from a naturopath). Documented competencies are sighted in this resident’s files, with reassessment of competency for self-administration conducted as last assessed in May 2014.   
  
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.

**Attainment and Risk:** PA Low

**Evidence:**

The current controlled drug register is commenced on 28 April 2014. One of the controlled drugs sampled has the ‘weekly stocktake’ recorded on 19 May 2014 and the next check recorded on 3 June 2014 (15 days between recorded checks). The one other controlled drug in the register sample has the weekly check consistently recorded at weekly intervals (12, 19, 26 May and 3 June).

**Finding:**

One of the controlled drugs sampled has a 15 day period between the stock count recordings.

**Corrective Action:**

Ensure the weekly stock count of the control drugs are consistently recorded at weekly intervals.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.12.6 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: There is a food services manual which describes all safe food processes.

The menu is last reviewed by the kitchen staff and owner against the national guidelines for older people living in aged care and the Heart Foundation guidelines for the older person. The menu is last reviewed in May 2014. The menu is a six week rotational menu with seasonal variations (eg, summer, autumn, spring and winter menu). The service receives regular updates from a dietetic association, which provides best practice strategies for the provision of food and nutritional services for residential care.

Every resident has a nutritional assessment review on entry to the service (and reviewed when indicated) and all residents are routinely weighed at least monthly. The cook also asks the residents what they would like for meals. There is a monthly kitchen audit that includes feedback on the quality of the meals. Interviews with four of four residents confirm they are satisfied with the food service and that their likes and dislikes are catered for. They report that if there is something they don’t like, there are always alternatives offered.   
  
Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The diabetic or special diets are clearly specified. One resident interviewed reports that they require a gluten free diet, and the resident indicates that the service caters for this well (they report that the food is better then what they had at home).   
  
There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. When food is decanted from its original packaging, the food is stored in food safe containers, labelled and dated. Any food that is returned to the fridge is covered, labelled and dated. Kitchen staff have completed food safety qualifications and receive ongoing education related to their role. .   
  
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:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.4: 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:**

Documentation Review: Policy states that all chemicals potentially hazardous to health are stored securely in order to minimise the risk of accidental exposure or ingestion by residents, staff or visitors to the facility. Policies and procedures identify that waste and sharps are appropriately disposed of.

The above policies and procedures are implemented as observed at the onsite audit. The chemicals are observed to be securely stored in the laundry, cleaners’ cupboard and sluice rooms. The laundering of the linen is conducted on site as part of the caregivers’ duties. The staff who participate in the laundry and cleaning report that they follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation.

There is appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The two caregivers interviewed report that they have had training in the handling of waste or hazardous substances, which is conducted by the manager and as part of the ongoing in-service education programme, last conducted March 2014 (all care staff who participate in the laundry service completed the training).

##### **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.

**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 1.4.1.6 (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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building warrant of fitness expires April 2015.   
  
Equipment is maintained to ensure safety. Electrical tag and testing was last conducted in September 2013 and is routinely conducted on a 2 year cycle. The calibration of the medical equipment is last conducted in April 2014 (includes scales, nebuliser, electric beds, sphygmomanometers, thermometer). The facility is demonstrating generalised wear and tear that is reflective and acceptable for the age of the building. The service has a planned and reactionary maintenance programme, with the building maintained in an adequate condition appropriate to the age of the building. The maintenance log notes areas of work required and is signed off when the work is completed.   
  
The fittings and furniture installed are maintained to ensure safety and the needs of the residents. The furniture cleaning is part of the planned maintenance and cleaning programme. The physical environment is appropriate for the residents. Hand rails are installed in corridors. There is disability access at all entrances. The residents’ rooms sighted are personalised with the resident’s possessions. Residents are provided with safe and accessible external areas that meet their needs. There are disability access ramps to the gardens and the service also has an internal courtyard area off a lounge room, with this area containing a garden that is maintained by the residents.  
Hot water temperatures in resident areas are monitored monthly. The temperatures sighted are within the safe temperature guidelines for aged care.   
  
The new owner has no immediate plans to make any environmental changes to the facility.

##### **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:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/showers/bathing facilities, conveniently located and in close proximity to residents’ rooms. There are sufficient toilets and bathrooms to service the residents. The toilets and showers are clearly identified with signage of engaged/vacant privacy notices. The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines. The four of four residents and three of three family/whanau report satisfaction with the toilets and shower facilities.

##### **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 rooms sighted are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents can freely move around the facility. The four of four residents and three of three family/whanau interviewed report satisfaction with their rooms and all state that they really appreciate the large size and outlook of the rooms.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are two lounges and one and dining area in the facility. The rest home has a separate family/whanau room if required. The lounge and dining area are separate and activities in these areas do not impact on each other. The residents’ rooms also have space for family/whanau if the resident wishes to entertain in their room. Most rooms have direct access through ranch sliding doors to a veranda. The four of four residents and three of three family/whanau interviewed report satisfaction with the lounge and dining facilities.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: Cleaning and laundry services policies and procedures sighted.

The laundering of the linen is conducted on site by care staff as part of their role. The laundry has a dirty to clean flow. The cleaning and caregivers interviewed who assist with laundry services report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. The four of four residents and three of three family/whanau interviewed report satisfaction with the cleaning and laundry services.

##### **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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has adequate emergency supplies in the event of an emergency or infection outbreak. The cook reports there is a least two weeks supply of food at all times. The service has stores of drinking and non-drinking water for emergency use including tank water. There is a civil defence kit with additional food, first aid and emergency supplies. In the case of mains failure the service has access to emergency lighting, and gas cylinders supply gas for heating and cooking. The service has a fireplace in the lounge and adequate supply of dry wood.  
  
All residents’ rooms, bathrooms and lounge areas have a call bell system installed. The call bell system has an audible alert, a light that comes on above the door if the call bell is activated and panels in the corridors. The call bell system is monitored for response times, with no ongoing issues indicated for the timely response to call bells. The four of four residents and three of three family/whanau report that the call bell is answered in a timely manner.   
  
The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The three of three clinical staff interviewed demonstrate knowledge on responding to emergency situations. The registered nurse has a current first aid qualifications (last updated in February 2014) and there is at least one staff member on duty at all times that has the current qualification.   
  
There have been no changes to the layout of the service that have required changes to the approved evacuation scheme. The service conducts six monthly evacuation training, with the last drill conducted March 2013. The service then conducts a fire and safety questionnaire for staff to complete.   
  
The service identifies and implements appropriate security arrangements relevant to the residents at the rest home. The afternoon staff are required to close and lock the external windows and doors before it gets dark and a security gate in the front driveway that has automated access in the day time. The service has external security lighting. The three of three clinical staff interviewed report that they feel safe and secure when working afternoon and night shifts. The four of four residents and three of three family/whanau interviewed report they feel safe and secure at night.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

Areas used by residents and staff are ventilated and heated appropriately. The service has a combination of wall panelled heating and heat pumps to provide heating in resident areas. All resident-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light and ventilation. The four of four residents and three of three family/whanau report satisfaction with the natural light, ventilation and heating.

##### **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:**

Documentation Review: Policy indicates the service is committed to providing a restraint free environment. There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety.

There are no current residents that have restraint or enabler use. The two of two caregivers and one RN interviewed demonstrate understanding that enabler use is voluntary and the least restrictive option.

##### **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:**

##### **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.)*

# 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

**Attainment and Risk:** FA

**Evidence:**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters within the organisation leading to the senior management. The infection control coordinator is the manager and they have a job description that has the role, responsibilities and accountability for infection matters (sighted).   
  
The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. The annual review was last conducted in May 2014. The annual review covers quality improvements, policies, procedures, surveillance, staffing, standard precautions and education.   
  
Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. There is a policy for staff not to come to work if they are unwell, there is a notice at the front door advising visitors not to have contact with residents if they are unwell or have been exposed to infections, and at times residents may be isolated where possible and practical. During a recent scabies outbreak there were designated chairs for residents and the van seats had protective covers. Their service has one resident with a diagnosed multi-resistant organism, who likes to set the tables in the dining room, this resident wears personal proactive equipment, when doing this task. The four of four staff interviewed demonstrated good knowledge of infection prevention and control.   
  
The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: Policy states that every infection is reported on an infection report form; this information is collated monthly and reviewed and analysed by the infection control coordinator who will advise management of the outcome. The infection control coordinator has access to adequate resources to enable then to achieve their responsibilities.

The infection control meeting is incorporated into the staff meeting. The infection control coordinator communicates the monthly infection control report to the staff through monthly email notices. The infection control coordinator has the range of skills, expertise, and resources necessary for the implementation of the infection control programme. The infection control coordinator reports that advice was sought from the GP, DHB and infection control specialist on the management of scabies.

ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.3: 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

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: There is a full suite of policies and procedures that reflect current accepted good practice and meet relevant legislative requirements.

The service utilises updates from an aged care consultant to review their organisational policies. The staff observed at the time of audit demonstrate good infection prevention and control techniques. The four of four staff demonstrate good knowledge of policies and procedures for infection prevention and control.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. The infection control coordinator and specialist infection control resources are utilised for the staff in-service education. The infection control coordinator attends ongoing education on infection control, the most recent in May 2014. The infection control coordinator demonstrates knowledge of current best practice for infection prevention and control.   
  
Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control coordinator has conducted informal education with residents such as education on the recent scabies management. The four of four staff interviewed report they receive adequate education on infection prevention and control.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.5: 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.

**Attainment and Risk:** FA

**Evidence:**

Documentation Review: The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy.   
  
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. The monthly surveillance data is collated and analysed by the infection control coordinator. The surveillance data and analysis of infections for 2013 records that upper respiratory tract infections are the most common infection over the year, which shows that these are indicative of resident mobility and seasonal infections. The service has had a recent outbreak of scabies and there has been ongoing analysis and management of the outbreak process. The service has sought infection control and outbreak advice from the DHB and GP in the treatment and management of the scabies. The action plan for the outbreak management includes contributing factors to the event, treatment, review of systems and the environment.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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.)*