# Remuera Rise Limited

## Current Status: 3 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

This is the first full certification audit for Remuera Rise. The service provides 12 beds in a 'designed for purpose' care facility on the ground level of a high rise retirement village. Since opening in 2013 the facility is maintaining a moderate to high occupancy, providing care to people assessed as requiring rest home, and short stay respite and/or recovery after treatment. On the days of this audit 11 beds are occupied.

There are no areas requiring improvement as a result of this audit.

All areas that required remedial actions at the provisional audit in August 2013 are now implemented.

## Audit Summary as at 3 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 3 July 2014

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

### Organisational Management as at 3 July 2014

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

### Continuum of Service Delivery as at 3 July 2014

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

### Safe and Appropriate Environment as at 3 July 2014

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

### Restraint Minimisation and Safe Practice as at 3 July 2014

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

### Infection Prevention and Control as at 3 July 2014

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

## Audit Results as at 3 July 2014

### Consumer Rights

The residents receive services that ensure their rights are maintained. The residents and families interviewed report satisfaction in the manner in which services and care is provided at Remuera Rise. The residents and family are informed of their rights on admission to the service, with information and brochures on complaints, rights, advocacy services and the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) available in a pack in each resident’s room and on public display. The resident receive services that respect their independence, privacy, dignity and respect.

There are policies and procedures in place that recognise and respect Maori and individual resident’s cultural values and beliefs. Residents receive services that are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

The service provides an environment that encourages good practice, which includes evidence-based practice. The organisation has links with an external aged care quality consultant and policies and procedures that reflect current accepted good practice. The service has a specialist focus on the provision of palliative care, with ongoing education and practices provided that meet the end of life needs for these residents.

Staff communicate effectively with residents and family/whanau to provide an environment conducive to good communication. The resident’s rights to full and frank information and open disclosure from staff is provided. Wherever necessary and reasonably practicable, interpreter services are provided.

Residents, and where appropriate their family/whānau of choice, are provided with the information they need to make informed choices and give informed consent. Written consent is documented in the residents’ files. Advance directives that are made available to staff are acted on where valid.

Residents are able to maintain links with their family/whānau, with visitors of choice encouraged to visit the residents. Residents are supported to access services within the community when appropriate. The service is located in an urban area with public transport close by.

The complaints management system is effective. Residents and their families are well informed about how to raise concerns. All complaints and concerns are logged in the complaint register, immediately acknowledged and investigated. There is evidence that the small number of complaints received to date have been resolved efficiently and to the satisfaction of all parties. There have been no complaint investigations by the Health and Disability Commissioner. There have been no Police, Accident Compensation Corporation (ACC) or Coroner investigations.

### Organisational Management

The governing body has established systems which define the scope, direction and goals of the facility. Monitoring and reporting processes against these systems are well maintained by the Clinical Manager. The Clinical Manager is a suitably qualified NZ registered nurse with recent and previous experience managing aged care facilities. The service complies with all relevent legislation and the care services are provided in a safe and efficient manner.

There is a documented quality and risk management system in place, including an internal audit programme. Quality improvement data is analysed and reporting of quality and risk information is shared with all staff, management and governance at regularly scheduled meetings. The adverse event reporting system is well established. All events are reported and documented and thoroughly investigated to identify any causes. Where causes are identified, actions are taken to minimise or prevent events recurring. The accident and incident documentation shows that the residents’ family members are consistently contacted following any adverse event which impacts them.

The management of human resources adheres to best known employment practice. Education to all levels of staff is provided at least monthly. Staff records provide evidence that good employment processes are followed and individual training records are maintained for all staff. Annual practising certificates are current for all staff who require them. All new staff reliably participate in and complete a comprehensive orientation programme.

Staffing levels and skill mix is determined by a documented rationale which considers the number of residents and their acuity. Care is provided by a ratio of four care staff (RN and healthcare assistants) to twelve residents. All staff, residents and family members interviewed report there are good levels of staff available at all times. There is at least one registered nurse on site for all shifts and more on call twenty four hours a day seven days a week.

The service has implemented policies around the management of consumer records. All entries into the integrated file are legible, signed and dated. Resident information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. There is no private information that is publically displayed or publically accessible.

### Continuum of Service Delivery

The service has a clearly documented criteria for access, entry or declining entry to the service. The service provides rest home and hospital level of care to long-term and shorter term/respite care residents. At the time of audit, the service has a close link with the local hospice service to provide palliative care for hospice clients who require support in a residential facility.

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 observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who participate in medicine management are assessed as competent to perform the role.

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.

### Safe and Appropriate Environment

The service has clear policies and procedures for the effective management of waste and hazardous substances. There are no incidents reported and staff receive training and education regarding safe and appropriate handling of waste and hazardous substances.

The building is new and due to have its code of compliance replaced by a building warrant of fitness. It complies with regulatory and legislative requirements and there are no issues with the building or its fit out. Monitoring and repair systems are in place to ensure that the physical environment and equipment is safe and well maintained.

Cleaning and laundry policies and procedures are implemented and monitored to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. Observatoins on the days of audit show that staff are using the personal protective equipment provided to them and that all cleaning and laundry equipment and chemicals are stored in a safe and hygienic manner.

Documented systems are in place for essential, emergency and security services. Staff interviews and review of files provides evidence of current training in relevant areas. Alternative energy and utility sources are installed and are being maintained appropriately. The call bell system is effective and there are functional security systems in place.

### Restraint Minimisation and Safe Practice

There are clearly described policies and procedures which provide guidance on the safe and appropriate management and minimisation of restraint and enabler usage. There is one resident requiring an enabler and there have been no restraint interventions to date.

All staff interviewed demonstrate a clear understanding of the requirements of this standard. A restraint and enabler register is being maintained. Restraint minimisation and managing challenging behaviour training has occured and staff complete restraint competencies regularly.

### 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 role of the infection control coordinator 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 had a number of months in 2014 where there have been no infections.

# HealthCERT Aged Residential Care Audit Report (version 3.92)

## **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:** | LifeCare Residences Ltd |
| **Certificate name:** | Remuera Rise |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | 30 James Cook Crescent | | | |
| **Services audited:** | Hospital-Medical/Geriatric; Rest Home | | | |
| **Dates of audit:** | **Start date:** | 3 July 2014 | **End date:** | 4 July 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 12 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 10 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 10 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 23 | Total audit hours | 47 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 8 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 18 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 22 July 2014

## **Executive Summary of Audit**

**General Overview**

This is the first certification audit for Remuera Rise. The service provides 12 beds in a 'designed for purpose' care facility on the ground level of a high rise retirement village in Remuera. Since opening in 2013 the facility is maintaining a moderate to high occupancy, providing care to people assessed as requiring rest home, medical or palliative care and short stay respite and/or recovery after treatment. On the days of this audit 11 beds are occupied. There are no areas requiring improvement as a result of this audit. All areas that required remedial actions at the provisional audit in August 2013 are now implemented.

**Outcome 1.1: Consumer Rights**

The residents receive services that ensure their rights are maintained. The residents and families interviewed report satisfaction in the manner in which services and care is provided at Remuera Rise. The residents and family are informed of their rights on admission to the service, with information and brochures on complaints, rights, advocacy services and the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) available in a pack in each resident’s room and on public display. The resident receive services that respect their independence, privacy, dignity and respect.

There are policies and procedures in place that recognise and respect Maori and individual resident’s cultural values and beliefs. Residents receive services that are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

The service provides an environment that encourages good practice, which includes evidence-based practice. The organisation has links with an external aged care quality consultant and policies and procedures that reflect current accepted good practice. The service has a specialist focus on the provision of palliative care, with ongoing education and practices provided that meet the end of life needs for these residents.

Staff communicate effectively with residents and family/whanau to provide an environment conducive to good communication. The resident’s rights to full and frank information and open disclosure from staff is provided. Wherever necessary and reasonably practicable, interpreter services are provided.

Residents, and where appropriate their family/whānau of choice, are provided with the information they need to make informed choices and give informed consent. Written consent is documented in the residents’ files. Advance directives that are made available to staff are acted on where valid.

Residents are able to maintain links with their family/whānau, with visitors of choice encouraged to visit the residents. Residents are supported to access services within the community when appropriate. The service is located in an urban area with public transport close by.

The complaints management system is effective. Residents and their families are well informed about how to raise concerns. All complaints and concerns are logged in the complaint register, immediately acknowledged and investigated. There is evidence that the small number of complaints received to date have been resolved efficiently and to the satisfaction of all parties. There have been no complaint investigations by the Health and Disability Commissioner. There have been no Police, Accident Compensation Corporation (ACC) or Coroner investigations.

**Outcome 1.2: Organisational Management**

The governing body has established systems which define the scope, direction and goals of the facility. Monitoring and reporting processes against these systems are well maintained by the Clinical Manager. The Clinical Manager is a suitably qualified NZ registered nurse with recent and previous experience managing aged care facilities. The service complies with all relevent legislation and the care services are provided in a safe and efficient manner.

There is a documented quality and risk management system in place, including an internal audit programme. Quality improvement data is analysed and reporting of quality and risk information is shared with all staff, management and governance at regularly scheduled meetings. The adverse event reporting system is well established. All events are reported and documented and thoroughly investigated to identify any causes. Where causes are identified, actions are taken to minimise or prevent events recurring. The accident and incident documentation shows that the residents’ family members are consistently contacted following any adverse event which impacts them.

The management of human resources adheres to best known employment practice. Education to all levels of staff is provided at least monthly. Staff records provide evidence that good employment processes are followed and individual training records are maintained for all staff. Annual practising certificates are current for all staff who require them. All new staff reliably participate in and complete a comprehensive orientation programme.

Staffing levels and skill mix is determined by a documented rationale which considers the number of residents and their acuity. Care is provided by a ratio of four care staff (RN and healthcare assistants) to twelve residents. All staff, residents and family members interviewed report there are good levels of staff available at all times. There is at least one registered nurse on site for all shifts and more on call twenty four hours a day seven days a week.

The service has implemented policies around the management of consumer records. All entries into the integrated file are legible, signed and dated. Resident information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. There is no private information that is publically displayed or publically accessible.

**Outcome 1.3: Continuum of Service Delivery**

The service has a clearly documented criteria for access, entry or declining entry to the service. The service provides rest home and hospital level of care to long-term and shorter term/respite care residents. At the time of audit, the service has a close link with the local hospice service to provide palliative care for hospice clients who require support in a residential facility.

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 observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who participate in medicine management are assessed as competent to perform the role.

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**

The service has clear policies and procedures for the effective management of waste and hazardous substances. There are no incidents reported and staff receive training and education regarding safe and appropriate handling of waste and hazardous substances.

The building is new and due to have its code of compliance replaced by a building warrant of fitness. It complies with regulatory and legislative requirements and there are no issues with the building or its fit out. Monitoring and repair systems are in place to ensure that the physical environment and equipment is safe and well maintained.

Cleaning and laundry policies and procedures are implemented and monitored to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. Observatoins on the days of audit show that staff are using the personal protective equipment provided to them and that all cleaning and laundry equipment and chemicals are stored in a safe and hygienic manner.

Documented systems are in place for essential, emergency and security services. Staff interviews and review of files provides evidence of current training in relevant areas. Alternative energy and utility sources are installed and are being maintained appropriately. The call bell system is effective and there are functional security systems in place.

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

There are clearly described policies and procedures which provide guidance on the safe and appropriate management and minimisation of restraint and enabler usage. There is one resident requiring an enabler and there have been no restraint interventions to date.

All staff interviewed demonstrate a clear understanding of the requirements of this standard. A restraint and enabler register is being maintained. Restraint minimisation and managing challenging behaviour training has occured and staff complete restraint competencies regularly.

**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 role of the infection control coordinator 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 had a number of months in 2014 where there have been no infections.

## **Summary of Attainment**

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 4 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

## **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. The two of two registered nurses (RN) and two of two health care assistants (HCAs) interviewed confirm they respect the resident’s right to refuse cares or interventions. Staff can verbalise ways they deal with situations that arise which ensure residents’ rights are maintained. This is confirmed during interviews with the four of four residents and five of five family/whānau members.

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:**

Stage one: The consumer rights policy outlines service requirements to meet residents’ rights within the facility.

Stage two: Opportunities are provided for explanations, discussion, and clarification about the 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 is clearly displayed at the entrance to the facility and available to residents and visitors. Interviews with four of four residents and five of five family/whānau report they are informed of their rights and that staff always respect all aspects of their rights.

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:**

The environment allows residents physical, visual, auditory and personal privacy. All rooms are single occupancy. There is an additional therapy room where family/whānau can talk in private with the staff. The door to each resident’s room has a glass panel, which can be obscured if the ensuite door is open when providing care, the clinical manager reports that the service is looking at installing a blind to the glass panel, which can be used to provide privacy at other times. There are two shared ensuites, in which the doors leading to the other resident room can be locked to ensure privacy in the ensuite.

Resident’s needs, values and 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 residents' files reviewed, which identify interventions implemented to meet the resident’s needs.

Residents and family/whānau report that they are treated with respect and that residents 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:**

The clinical manager reports that there are no known barriers to Maori accessing the service. Currently there are no residents who identify as Maori. The clinical manager reports that the service has had previous residents who identify as Maori. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with the two of two RNs and two of two HCAs. The ongoing education programme includes cultural aspects of care. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents.

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:**

Interviews with four of four residents and five of five family/whānau members confirm they are consulted on their/or their relative’s individual values and beliefs, and that care is planned and delivered to meet individual resident’s needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care plan. At the time of audit there are no residents of different cultures at the service. The clinical manager reports that there have been residents of different cultures, including a resident from Iran, in which the resident and family had specific cultural values and beliefs that staff respected.

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:**

The six of six staff records reviewed 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. The four of four residents and five of five family/whanau confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. The code of conduct is part of the ongoing education.

##### **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:**

Interviews with two RNs and two HCAs 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. The policies and procedures are reflective of current accepted good practice and referenced to current research. The service has access to an aged care quality consultant. The service has an ongoing focus on providing specialised support to the community palliative care service. The interview with the hospice RN reports that they highly recommend the service for the provision of its palliative care services.

The GP visits regularly and the service has established links with other local health services such as the local hospice, DHB and mental health support groups. The gerontology nurse specialist visits residents as required and to deliver specialist education to staff. There is regular in-service education and staff access external education that is focused on aged care and palliative care. All educational material sighted shows this is evidenced to current best practice standards.

Interviews with four of four residents and five of five family/whānau members confirms their high level of satisfaction with all care delivery and staff attitudes. One family member states that there are some ‘super star’ staff at Remuera Rise.

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:**

Open disclosure procedures are in place to support staff to maintain open and transparent communication with residents. Four residents’ files reviewed show that communication with family is being consistently documented in the resident's progress notes. Family members interviewed during this audit advise they are contacted if their family member has an accident/incident, and if there is any change in their condition. Residents and family interviewed state that service providers have sufficient time for discussions, appropriate spaces for discussions are available at all sites, and that they are given time to talk about the care they are receiving. Residents interviewed confirm that they are aware of the staff who are responsible for their cares.

The managers advise access to interpreter services is available if required via the DHB, although they report they have not required interpreter services.

Interviews with five of five family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. The resident, and family/whānau, are invited to attend the multidisciplinary team (MDT) review and they have documented input into setting annual goals and evaluating services that are in place. Family/whānau communication is clearly documented in the four of four residents files reviewed, on incident and accident forms sighted and in the written handover sheets.

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:**

Signed consent forms are sighted in the four of four residents’ file reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with four of four residents and five of five family/whānau members. All four residents’ files have a signed advance directive identifying the resident’s chosen wishes related to resuscitation status. With a focus on palliative and end of life care, the staff have a good understanding of advance care planning and the end of life wishes of residents are clearly documented. Four of the seven files reviewed have a copy of nominated enduring power of attorney (EPOA) for either finance and/or health decision making. The two of two RNs and two of two HCAs verbalise 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:**

The four of four residents' files reviewed and interviews with four residents and five family/whānau members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau is encouraged to involve themselves as advocates. 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 five of five family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.

The service is located within a retirement village, with easy access to public transport to the local community. Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. The organisation is in the process of reviewing the planned activities provided, to ensure ongoing support for residents to access external grounds and services within the community. Residents often go out with friends and family. There is a hairdresser at the service that the residents can access. Residents are welcome to have their own spiritual advisor visit or to attended service 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:**

**Document Review**: The complaints policies and procedures are clearly described and compliant with Right 10 of the Code.

Complaint forms are readily accessible and/or displayed. Interview with four residents and five relatives confirm they are advised on entry to the facility of the complaint processes and the Code. Staff attend regular education on the Code of Rights including complaints processes.

The implemented complaints management system is effective and the complaints register is up to date and contains sufficient detail about each complaint logged in it. There are three complaints received in 2014, none of these are serious. Review of the complaints documentation, interview with the clinical manager, telephone interview with a relative and an external health professional regarding a recent concern, reveals that complaints are fully acknowledged, well managed and resolved.

The service meets the ARC requirements.

##### **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:**

The organisation is maintaining and updating its two year business plan 2013-2015 as required. Evidence is sighted that this has been reviewed for progress by the Clinical Manager (CM) in June 2014. The plan clearly describes the scope of services (eg, retirement village with onsite hospital and rest home level care facility with a maximum 12 beds). The plan includes an accurately described vision, service philosophy and current goals.

The CM is a NZ registered nurse with four years’ experience managing aged care facilities. This person was appointed in December 2013. The manager has a current practising certificate and is maintaining her nursing portfolio by attending ongoing education in subject areas relevant to older people. This includes clinical refresher training, infection control, management seminars and maintaining a first aid certificate. The manager is a national and regional committee member of the NZNO gerontology section and is also a member of a cluster of local age care providers who meet locally every two to three months.

The service meets the ARC requirements.

##### **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:**

The CM reports to the Village Manager who reports to the General Manager (GM). Reports occur verbally and via monthly written reports which contain detailed information about the care facility, including adverse events, complaints, staffing matters, occupancy and quality data.

The CM and GM meet weekly at heads of department meetings. The GM interviewed states that the frequency of meetings and information gathered and reported on each month, provides accountability and monitoring of efficient, safe and effective services to residents.

The nominated second in charge is the clinical co-ordinator who is a RN with skills, knowledge and experience in aged care. This person interviewed demonstrates competence and understanding of the role.

The service meets the ARC requirements.

##### **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:**

**Document Review:** The quality and risk policies, plans and framework, and the health and safety documentation are clearly described and meet the requirements of this standard.

The service contracts an external quality consultant (HealthCare Compliance Solutions Ltd) who provides detailed and best practice policies and procedures and regular oversight with quality and risk monitoring. All quality and risk systems are well established and geared toward continuous quality improvement. All care facility staff and senior management are directly involved in and are kept updated about quality and risk matters.

Internal audits are co-ordinated by the CM. The sighted schedule for 2014 along with records of the internal audits completed to date, demonstrate that all areas of service delivery are monitored and where deficits are identified these are addressed by implementing corrective actions. There is a clear and easily understood system for collection and analysis of quality data (eg, accident/incidents and other events, internal and external audit outcomes, complaints, infection control events, health and safety matters and restraint usage).

All quality and risk issues are reported at monthly staff meetings. Meeting minutes reviewed demonstrate that issues, including the type and number of events, is discussed in depth with an emphasis on minimising and preventing recurrence.

The Health & Safety Manual includes relevant policies and procedures. The hazard reporting system is effective and the CM is maintaniing a detailed Hazard Register. Material Safety Data Sheets are available and located in all areas where chemicals are stored. Planned and reactive maintenance and equipment checks and calibration is carried out regularly by maintenance personnel and external agencies. This is confirmed by review of maintenance records and interview with the CM and maintenance personnel

Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and that they are advised of new or revised policies. All care staff interviewed confirm that quality improvement data is regularly shared with them.

The service meets the ARC requirements in regards to quality and risk management.

##### **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:**

**Document Review:** There are clear and detailed policies and procedures for the reporting, investigation, and follow-up processes for adverse events.

The system in place is effective and procedures are adhered to. Adverse events (accidents/incidents and medicine errors) are recorded and reported to the CM who investigates and analyses these as they come to hand and collates these into month by month data.

Family members interviewed state they are reliably informed following any adverse events that directly involve their relatives. Contact with family is also documented on the event form and in the residents’ records. There is an open disclosure policy. There have been no serious or sentinel events. The rate of falls, skin tears and medicine errors is low taking into account the acuity and dependancy of residents.

Staff confirm during interview that they are made aware of their essential notification responsibilities through job descriptions, policies and procedures and professional codes of conduct. Policy and procedures comply with essential notification reporting (eg, health & safety, human resources, and infection control matters)

The service meets the ARC requirements

##### **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:**

There is evidence that staff are recruited using good employment practices. Evidence that qualifications are checked, interview questions and responses are documented, and there are records of reference checking, police checks and letters offering employment is sighted. All registered health practitioners have current membership and/or current practising certificates.

The orientation programme is comprehensive and specific to the care facility. The programme includes all expected subject areas for consumer rights, day to day practices (eg, showering, infection prevention guidelines, cleaning and laundry, food safety, falls prevention, emergency preparedness, accident incident reporting, restraint and managing challenging behaviours, and medicines management).

There is a well-planned and implemented staff education programme which is moderated and overseen by one of the RN's. The training schedule categorises compulsory topics and the frequency of these. All staff attend regular (records show on average monthly sessions) and ongoing education sessions which are relevant to the care of older people and palliative care. Review of HR and attendance records show that RN's, EN's and the DT hold current comprehensive first aid certificates. All care and nursing staff complete annual competencies in medicines management, restraint/enablers, death/tangihana, infection prevention and control, documentation-handover, Privacy Act-confidentiality, sexuality and intimacy, and conflict resolution. Attendance at one of the six monthly fire drills is compulsory at least once a year. All other topics are compulsory to attend at least biennially ( eg, ageing process, Advocacy, Complaints, Informed Consent, Abuse and Neglect, Advance Directives and resuscitation, Open Disclosure and other consumer rights knowledge, Continence management, weight loss, pain management, skin and wound care, grooming and personal hygiene, safe food handling, and challenging behaviours. There is also evidence that the visiting Hospice staff are providing ongoing education and support to care and nursing staff about palliative care and the Liverpool Care pathway. This is confirmed by interview with a visiting Hospice worker, interview with the CM and review of personnel records.

There is 24 hour seven day a week (24/7) medical cover by a registered medical practitioner. The locum GP was interviewed. The GP provided favourable feedback about the care being provided at Remuera Rise, how well staff communicate and their skills and competence to carry out prescribed treatments.

The service contracts a registered dietician, and a podiatrist. An activities coordinator is now part time employed.

The service meets the ARC requirements.

##### **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:**

**Document Review:** The staffing rationale provides clear guidelines on the ratio of RNs and HCAs to the number and acuity of residents. As well as the full time employed RN care manager and the RN clinical coordinator being available for 40 hours per week, there is an RN and two health care assistants (HCAs) on morning and afternoon shift and one RN and one HCA at night.

In total there are six permanent and four casual healthcare assistants employed and five FTE RNs, including the RN clinical co-ordinator who is nominated as second in charge of the care facility. This gives a ratio of one HCA or RN to four residents. Other allied staff have specified hours as follows: two cleaners/laundry people for five hours per day seven days a week, and an activities co-ordinator for twelve hours a week. Other allied staff such as cooks, maintenance and administration staff are employed for sufficient hours to provide services to the care facility

This is confirmed by interview with the CM, the GM and eight staff and reviews of recent work rosters.

The requirements of the ARC contract are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** 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 in the nurses’ station and is not accessible or observable to the public. Staff make entries each shift into the resident progress notes and their name and designation are clearly shown. All individual resident records are integrated and all health care providers write in the same set of notes in chronological date order in the progress notes. It is noted that there is one staff member that did not consistently record their designation, though this does not reflect a systemic issue. The four of four residents files reviewed demonstrate service delivery is integrated.

The ARRC requirements are met.

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

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

**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:**

The service provides rest home and hospital level of care. The entry criteria, assessment and entry process is clearly documented and communicated to the potential resident and family/whānau as confirmed during resident and family/whānau interviews. The five of five family/whānau members confirm all information was explained and factual when they made enquiries and during the admission process. The Eldernet information is updated daily (Monday to Friday). The service has a good working relationship with the local referral agencies who are aware of the service level offered. The service has a close relationship with the local hospice and has become a preferred provider for palliative residents that require longer term care. The clinical manager reports that if residents need a different level of care, such as secure care, these residents are reassessed as soon as possible to ensure the appropriate level of care is obtained for the resident.

ARRC requirement 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:**

The manager reports that no residents who meet the entry criteria have been declined entry if a bed is available. They report that if a resident was to be declined entry other options or alternative service information would be offered to the applicant or their family/whānau.

The sighted admission agreement contains information on the termination of the agreement. The admission agreement describes if the resident’s needs change and the service can no longer provide a safe level of care to meet the needs of the residents, the service will assist in providing a more suitable service provider (eg, secure dementia level of care).

##### **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:**

Each stage of service provision is undertaken by a RN who is suitably qualified and/or experienced to perform the role. The RNs are responsible for assessment, planning, provision, evaluation, review, and exit, with consultation with the HCAs, activities staff, GP and family/whānau communication. The main provision of care is provided by the HCAs. Annual practising certificates are sighted for all staff who require them.

The service has not commenced the use of interRAI assessments; training is scheduled for August 2014. The service currently has a paper based assessment and care planning tools. The clinical manager reports that when the electronic interRAI assessment training is complete, the service has plans to introduce electronic care plans that complement the interRAI assessment tool. The initial assessment covers the resident’s medical condition and nursing assessments for physical, emotional, pyscho-social, spiritual and cultural needs. The organisation’s care plan format includes the issues, goal, interventions and evaluation of care. The initial assessment and initial care plan is conducted on the day of admission. The long term care plan is developed within three weeks of admission. The long term care plan is reviewed at least six monthly, with more frequent evaluation occurring to reflect the resident’s changed needs. The care plan is based on the assessed needs of the resident and includes the physical, psycho-social, cultural and spiritual needs of the resident. Multidisciplinary reviews are undertaken at least six monthly (or more frequently to reflect changes in the resident’s condition) and documentation and resident and family/whānau interviews confirm their involvement in initial and ongoing care decisions and planning.

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. There are entries into resident progress notes each shift that record care provided and any additional changes that may be required. The GP reports there is good communication with the staff and other health professionals (eg, hospice team) to ensure continuity of care.

Interviews with two RNs and two HCAs confirms that they receive appropriate information during handover to ensure all resident cares can be delivered in a manner to meet their identified needs.

At the time of audit there are 10 hospital level of care and one rest home level of care residents. The rest home resident admission is under 7 days and therefore there was not sufficient information to review as a tracer methodology example. The rest home level of care resident is included in files sampled.

Tracer example one – hospital level of care.

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:**

The four of four residents’ files reviewed evidence that the needs, outcomes, and/or goals of residents are identified through the assessment process and serve as the basis for service delivery planning. The assessment tools include continence, hygiene and personal grooming, pressure area care, skin management, falls, continence, wound management, pain, social activity and restraint as required. The resident reviewed has assessments for the management of their symptoms related to their terminal disease. Two of the residents’ files reviewed are of residents that are assessed as high falls risks, and these residents have additional assessments and post falls assessments that provide strategies for preventing and minimising falls. The four of four residents and five of five family/whanau report that the residents are provided with care that meets their needs.

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 four of four residents’ files reviewed (three hospital and one rest home) identify that care planning is individualised to reflect resident’s assessed needs and interventions and support systems are clearly shown. Input from all health care providers and the assessment process inform care planning which is reflective of the needs of the resident. The resident reviewed records interventions to support their palliative needs. Interviews with four of four residents and five of five family/whānau members report all care is provided to meet their needs by staff who have excellent knowledge and skills.

The care plans demonstrate integration of service delivery. 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.

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 service has adequate dressing and continence supplies to meet the needs of the residents. The four of four care plans reviewed (three hospital and one rest home), record interventions that are consistent with the residents' assessed needs and desired goals. The file of the rest home resident reviewed, has an initial care plan that records the residents needs till their long term care plan is developed. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The four of four residents and five of five family/whanau interviewed report that the service meets the needs of the residents. The resident reviewed records interventions to meet the resident’s desired goals.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The activities co-ordinator reports activities plans are individualised to the resident’s needs. The activities are developed in conjunction with the resident and where appropriate their family. A monthly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. There are group and one to one activities provided. The activities co-ordinator reports where residents have a specific need, the service endeavours to provide the resources for this. For example a resident wished to have a meal with previous colleagues, and this was organised.

The activities programme and allocated hours for planned activities is currently under review. At the time of audit there is 12 hours a week that the activities coordinator is on site. The service has a number of residents for palliative/end of life care and the activities provided are meeting these resident’s needs. The service has now an increasing number of longer term residents at rest home or hospital level of care, with the programme under review to ensure the needs of the longer term residents are met.

The four of four residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with person centred care plan reviews and multi-disciplinary reviews.

Where possible residents' independence is encouraged to maintain links with family and community groups. The service is located within walking distance to a city shopping area and easy access to public transport.

The four of four residents interviewed report there is an adequate range and variety of planned activities. Resident and family/whanau access to the recreational facilities in the retirement village is assessed on an individual basis.

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:**

Three of the four care plans reviewed evidence evaluations of care. The remaining rest home resident reviewed has an admission under seven days and has not required an evaluation of care to date. The RN interviewed reports that this resident’s initial care plan and the use of ongoing assessments will be evaluated to develop the resident’s long term care plan within three weeks of the resident’s admission. The documented evaluations indicate the resident's progress in meeting goals, and care plans are updated to reflect progress towards meeting goals.

Where progress is different from expected the service either updates the long term care plan or uses short term care plans for temporary changes. Three of the four residents' files reviewed have a short term or acute care plan for a temporary change of condition. The remaining resident has an admission under one week and therefore is not due for evaluation. The four of four residents and five of five family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.

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 four of four resident file reviews. Health services accessed include general medicine, surgical services, cardiology, radiology, dietician, mental health, ophthalmology, immunology and oncology. The GP confirms that appropriate referrals to other health and disability services are well managed at the service. The resident reviewed has ongoing input from hospice and the district nurse.

The 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 on the transfer form and the ‘yellow envelope’ transfer system with the DHB. 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 and the transfer envelope if the resident is going to the acute care hospital. 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, 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. Two of the residents’ files reviewed have recent acute care hospital admissions and the organisational transfer process is sighted in these files.

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:** FA

**Evidence:**

Stage one: The policies and procedures sighted comply with legislation, protocols and guidelines, these include safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. Policy states that all staff responsible for medicine management are assessed as competent to perform the function for each stage they manage. There are policies, procedures and competency assessments to facilitate safe self-administration of medicines by residents where appropriate.

Stage two: Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The signing sheet that records the sachets are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit.

Medicines are stored in a locked medicine trolley and in the locked treatment room. There is a monthly stock rotation recorded for the medicines that are not packed in the sachets. The controlled drugs are stored in a locked safe at the nurses station, two staff sign the register at each administration and a weekly stock count is undertaken. The service's medicine fridge is monitored daily and temperatures are within recommended guidelines.

The eight of eight medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose and time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for the staff designated as responsible for medicine management.

The RN reports that there is one resident assessed as competent to self-administer their medicines. The self-administration competency for this resident is sighted.

The ARRC requirements are met.

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

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

**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 1.3.12.3 (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:**

Stage one: The nutritional plan and policy is based on the Food and Nutritional Guidelines for Healthy Older People. The residents’ input into food services is sought through annual resident surveys and resident meetings. There are policies and procedures for all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal that comply with current legislation, and guidelines.

The eight week rotating menu, with seasonal variations, is reviewed by a registered dietician in April 2014 as suitable for aged care residents. The menu review is based on the dietician NZ audit tool for residents living in long term care. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The care staff manage the additional food supplements for the residents (eg, Fortisip). The kitchen clinical manager reports that they visit all resident to get feedback on the meals provided and preferences of each of the residents. The resident reviewed has specific dietary needs, and the kitchen clinical manager reviews the menu with this resident on a weekly basis. The residents report high satisfaction with the food and fluids provided.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken twice daily and meet requirements. All foods sighted in the pantry and freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery.

##### **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:**

**Document Review:** There are clearly described policies and procedures for the safe handling of waste, infectious or hazardous substances, use of PPE, management of incidents involving infectious material, needle stick injuries, and contact with blood and body substances.

Protective clothing and equipment is available and in use (eg, goggles/visors, gloves, aprons, footwear, and masks). Containers of disposable gloves and hand sanitizer liquid are located throughout the facility. There have been no incidents involving waste or hazardous substances and observation and interview with staff on both days of audit demonstrates use of PPE and careful handling, and safe and appropriate storage and disposal of waste.

##### **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 care facility has 12 spacious rooms which are designed and built to the NZ disability standard. Corridors are wide and safety rails are installed at the correct height for safe mobilisation. Automatic opening doors on the lift and in communal dining area are deliberately slow for older people. The building is still under its original certificate of compliance issued by the Auckland City Council dated 01 August 2013 and work is in progress to replace this with a building warrant of fitness.

Each room is fitted with an Argo overhead hoist with tracks that lead from bed to bathroom. All other equipment necessary for hospital care is in place and is being checked, calibrated and maintained by BV medical. These include an electronic chair scale, suction equipment, nebuliser, and an oxygen concentrator, a standing hoist and other medical equipment.

There are no changes in floor surface and levels. Carpet and vinyl floor surfaces are heavy strength, easily sanitised and suitable for the services to be delivered. The layout of the facility maximises auditory and visual privacy. All external areas are designed to be safe and appropriate for older people. There is direct access to the outside with a safe walkway to the road facing deck/balcony area outside the dining room. All pavement surfaces are at the same level and non-slip, there is safe and adequate external seating suited to the consumer group. Shading and shelter can be provided for recreation or evacuation purposes.

Since the August 2013 provisional audit, a new and separate entrance to the care facility for visitors and ambulance has been installed. This is the only change to the building.

The facility meets the ARC contract requirements.

##### **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:**

Each bedroom has a disability accessible ensuite bathroom. There are two co-joined rooms with a shared ensuite. One of these is currently occupied by a couple and the other is occupied by residents of the same gender who agree to share. The toilet and shower ensuites meet the requirements of the New Zealand Building Code. The fixtures, fittings, floors and wall surfaces are constructed from materials that are easily cleaned. Each ensuite is designed to allow for use of mobility aids and provide working space for two to three care staff. Each bathroom has adequate systems for heating and ventilation, a high rise toilet, showers with flexible shower heads and easy to operate mixers, and a hand basin and vanity with sufficient storage. Approved grab rails are appropriately secured. There are commode shower chairs in each bathroom. Maintenance staff carry out weekly water temperature checks and records show that temperatures are consistently below 55 degrees.

There are extra staff and visitors toilets that are readily accessible.

##### **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:**

Each bedroom is fully furnished with a wide single high/low electric bed, a reclining arm chair, an additional chair and a lockable bedside cabinet. Access is through double doors which are wide enough to accommodate the standing hoist, and with all the furniture in place there is plenty of space for manoeuvring. Each room has a large built in wardrobe with shelving and drawers. There are sufficient and conveniently located power points and telephone jack points. There is a flexible hinged reading lamp above each bed. Flat screen televisions are installed in each room. All rooms have large opening windows with curtains for privacy.

##### **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 is a large separate dining area. This is furnished with three dining tables and chairs that are easy to lower into and get up from, and are stable and suitable for use by older persons. Two of the dining room walls are glass windows or sliding doors which provide excellent light and ventilation. Sliding doors lead to an enclosed deck/balcony with glass balustrade. The resident compendium states that residents are encouraged to join others in the dining room for lunch and dinner. The dining room space is also used for recreation and leisure activities outside of meal times. There is a large wall mounted television, a self-contained kitchenette and plenty of lockable storage cupboards for activities equipment.

##### **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:**

**Document Review:** There are fully described policies for cleaning and laundry which contain step by step procedures for implementing safe and hygienic practices.

Cleaning and laundry services are provided by part time staff employed to be on site five hours a day seven days a week and this is confirmed by interview with a cleaner and laundry person , the clinical manager, review of position descriptions and the staff roster. There is a suitably equipped laundry facility on site and separate storage room for cleaning products and equipment which is located in the basement but is readily accessible to the care facility. There are three laundry trolleys allocated for use by the care facility. One of these is designated for containment of infectious materials.

There are two cleaning trolleys plus one designated as the 'infectious' cleaning trolley. Location and storage of bulk chemicals is in the laundry which is in the basement below the care facility. Cleaning chemicals are provided by Ecolab (the Oasis system). These are dispensed from a wall mounted chemicals system in the cleaning store room as are laundry chemicals in the main laundry, so exposure is minimized.

Material Safety Data sheets are kept where chemicals are stored and are accessible for staff. Hazardous chemical substances are correctly labelled and the container is appropriate for the contents, including container type, strength and type of lid/opening.

Regular audits are conducted of cleaning and laundry to monitor adherence to procedures and the effectiveness of services. There have been no complaints or issues related to cleaning or laundry.

Cleaning and Laundry services meet the ARC contract requirements.

##### **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:**

**Document Review:** Emergency readiness procedures are in place for fire safety, earthquakes, flood, electrical storm, gas leak, loss of water, and electrical storms. There are separate policies for resident emergencies, such as, choking, poisoning, burns and allergies.

The facility has emergency backup lighting and generator system for power outages which lasts for 36 hours. There is an appropriately stocked disaster box in the main reception and there is adequate food and water supply for a maximum 12 hospital level care residents. Village residents are instructed to provide for themselves.

The building has a fire sprinkler system throughout with fire hoses and extinguishers in place. These and the exits are checked monthly by an externally contracted provider. The call bell system is functional and all residents interviewed confirmed that staff attend to call bells promptly. The calls register on an electrical board located opposite the reception desk/nurses’ station and on the RNs carry 'deck phones'/page. Emergency calls are linked to the rest of the building to alert all available staff.

Training and education in responding to emergency situations are part of the orientation process when staff commence employment.

Staff interviews confirm knowledge and understanding about emergency, security and fire safety procedures.

The fire evacuation scheme is approved by NZ Fire services on 26 June 2013 and fire drills are occurring six monthly. The most recent trial was 10 June 2014 and a full evacuation is scheduled for 14 July.

The facility has a built in security monitoring and intercom system. Building security is effective. There have been no incidents since opening.

The front door is locked at night time and access to the care facility, individual apartments and the rest of the building, is by intercom access and/or swipe cards.

The major incidents emergency plan and security arrangements meet ARC requirement of D15.3e and D19.6

##### **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:**

There is a gas fired central heating system installed throughout the building. Heat is provided by vents to communal areas and bedrooms. There are temperature control systems in each bedroom for residents to adjust individual room temperatures. All resident areas have windows and/or external opening glass doors which provide adequate ventilation. Residents, family members and staff interviewed state that building temperatures and ventilation/fresh air flow is safe and comfortable.

The ARC contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

**Document Review:** There are clear and detailed policies and procedures describing the use of restraints and enablers and the management of challenging behaviours. These meet the requirements of this standard and current best known practice. The policy describes a service philosophy of no restraint or using restraint as a last resort, the type of restraint interventions approved for use and a range of techniques to minimise the use of restraint. The enabler policy states that enablers are used at the request of the consumer to prevent harm, promote independence and that it will be the least restrictive option possible. The definitions of restraints and enablers are congruent with NZS 8134.2.2.

There are currently no residents requiring a restraint intervention and one enabler in use. One resident is seated in an arm chair with the foot stool raised for safety and comfort. Staff and the resident interviewed, review of care records and observations on both audits days confirm that the resident is not left seated in the armchair until all physical and other needs have been attended to (eg, toileting, fluids and food, safe positioning and placment of call bell). There are known maximum times for the resident to be in the chair and times in and out of the chair are recorded along with the care interventions provided in each time period.

Two RNs, two healthcare assistants and three managers interviewed are able to describe ways in which they minimise the use of restraint. Review of the annual staff education plan, training attendance records and six personnel records confirms there is regular ongoing staff education on preventing and minimising restraint and managing challenging behaviours. All staff also complete a self directed learning module and restraint competency test.

##### **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.)*

# 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:**

Stage one: The sighted policy on the infection control programme clearly identifies infection control measures, monitoring of infections and prevention of cross infection. The review of the infection control programme includes the review of the policies and procedures, health and safety risk management protocols, education and training, the monitoring, reporting and analysis of data and review of housekeeping, waste disposal and laundry operations. The programme review is used to identify trends and patterns, including opportunities for improvement through quality improvement processes.

Stage two: The infection control programme review sighted at the time of audit is dated June 2014.

One of the RNs is the infection control coordinator. There is a signed role description for the infection prevention and control coordinator which shows clear lines of responsibility and accountability for infection control matters in the service. Staff are kept fully informed of infections during handover, in residents’ progress notes. This is confirmed during the two RNs and two HCAs interviews.

With a recent increase in chest infections, unwell residents were encouraged to stay in their room where possible. The staff interviewed state they are encouraged not to come to work if they are unwell.

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:**

The infection control committee has access to persons with a range of skills, expertise and resources from external specialist infection control providers to ensure the documented goals for the infection control programme can be maintained. The infection control coordinator confirms that the service also has access to external advice through the GP, product supplier, specialist infection control specialists, DHB and Ministry of Health services as required. Infection prevention and control is incorporated into the monthly staff meetings to monitor infection rates and to put corrective actions in place as required. The infection control coordinator report they have adequate human, physical and information resources to implement the infection control programme.

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:**

Stage one: The policies and procedures sighted comply with relevant legislation and current accepted good practice. The policies and procedures are practical and appropriate to the type of service provided whilst complying with current good practice and meeting legislative requirements. The eight of eight staff report the infection control policies and procedures and ongoing education provide effective guidance for infection prevention and control at Remuera Rise.

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 external specialists and the infection control coordinator, who maintains their knowledge of current practice. The infection control coordinator has attended ongoing education on infection prevention and control, through the specialist infection prevention and control advisory service and has a post graduate qualification in infection prevention and control.

Staff education on infection prevention and control is provided as part of the orientation and ongoing education calendar sighted. Staff also have access to online learning modules for infection prevention and control. Interviews with eight of eight staff confirm their knowledge and understanding of infection control matters and reporting requirements. They confirm their education is understandable and related to the role they are employed to undertake.

Resident education is provided informally during cares, such as with recent chest infections, residents who were unwell were encouraged to stay in their room if possible. The infection control coordinator reports that there is ongoing informal education with residents on the importance of fluids and good hand washing.

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:**

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for the rest home and hospital level of care residents. The monthly report of collected data is provided to the care and village clinical manager and presented at staff meetings. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for 2014 records that there are three months with no acquired infections. The June 2014 infection surveillance data record that there are three recorded chest infections. The analysis records that is an increase that reflects seasonal and community norms.

##### **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.)*