# Summerset Care Limited - Summerset By The Lake

## Current Status: 27 May 2014

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

## General overview

Summerset by the Lake is owned by the Summerset Group and is currently certified to provide rest home level of care up to 18 residents in the stand alone serviced apartment building. This audit also assessed one more serviced apartment as suitable for rest home level of care. On the day of the audit, there were six rest home residents.

The village manager is experienced in aged care management and is supported by a clinical nurse leader.

Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Residents interviewed all spoke positively about the care and support provided.

There are no shortfalls identified at this audit.

## Audit Summary as at 27 May 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 27 May 2014

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

### Organisational Management as at 27 May 2014

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

### Continuum of Service Delivery as at 27 May 2014

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

### Safe and Appropriate Environment as at 27 May 2014

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

### Restraint Minimisation and Safe Practice as at 27 May 2014

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

### Infection Prevention and Control as at 27 May 2014

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

## Audit Results as at 27 May 2014

### Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family.

There are policies around cultural sensitivity and appropriateness with links to an Iwi and kaumatua when required. Residents confirm their spiritual needs are met.

Complaints policy and processes align with the code of rights. There have been no concerns or complaints registered in the last year. Residents and family interviewed praised the support and care provided.

### Organisational Management

Summerset by the Lake has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions. The quality, management and resident/family meetings serve to communicate any quality improvements. There are meetings at all levels to discuss quality data and improvements including the following: health and safety meetings with a focus on falls, infection control; staff meetings (includes all services); management meetings; quarterly resident/family meetings. New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are supported into the position. There is a comprehensive training programme in place with good staff attendance.

### Continuum of Service Delivery

 The registered nurse undertakes the assessments on admission. The initial support plan is completed within 24 hours of admission.

Within three weeks the long term care plan is completed by the registered nurse. The lifestyle care plans are completed comprehensively. The care being provided is consistent with the needs of residents. There is a short-term care plan that is used for acute or short-term changes in health status. Communication with family is documented in the progress notes and care plans. Service delivery plans demonstrate service integration with input from care givers, activities officers, GPs, specialist review and resident and family input where appropriate.

Residents are assessed by the general practitioner within 48 hours of admission.

Activities are planned that are appropriate to the functional capabilities of resident. Residents interviewed spoke positively about the activities programme. Activities are voluntary.

The medication management system includes medication policies and procedures that follow recognised standards and guidelines for safe medicine management practice in accordance with guidelines. Staff responsible for medication administration are trained, and competent.
All residents on entry to the service have a nutritional profile developed. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen. The menu is designed and reviewed by a registered dietitian.

### Safe and Appropriate Environment

Summerset by The Lake is a purpose built facility and is a well maintained home. The service has a current building certificate and maintenance is completed as required. There is enough room throughout the service for residents to mobilise safely. All resident apartments have ensuites. Fixtures, fittings and floor and wall surfaces are appropriate for this environment. Residents rooms are of sufficient space to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise safely. Residents are encouraged to bring in their own furnishings for their rooms. Hot water temperature is monitored monthly at 45 degrees. The service has in place policies and procedures for effective management of laundry and cleaning practices. The service has implemented policies and procedures for civil defence and other emergencies. Regular fire drills are completed and the annual training plan includes emergency training. General living areas and resident rooms are appropriately heated and ventilated.

### Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. There are no restraints or enablers in use.

### Infection Prevention and Control

There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. Infection control training is provided to staff at least annually.

All infections are entered into an on-line data base and monthly reports are generated. Infection control is a set agenda for discussion at monthly staff meetings and management meetings.

The infection control coordinator has access to the nurse specialist at the District Health Board, general practitioners and other specialists as required. There are policies and procedures in place that reflect current best practice. The programme is approved and reviewed annually and is appropriate to the size and complexity of the service.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| **Legal entity name:** | Summerset Care Limited |
| **Certificate name:** | Summerset Care Limited - Summerset By The Lake |

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

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| **Types of audit:** | Certification Audit |
| **Premises audited:** | Summerset By The Lake |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 27 May 2014 | **End date:** | 27 May 2014 |

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| **Proposed changes to current services (if any):** |
| Additional serviced apartment assessed as suitable for rest home level of care.  |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 6 |

## **Audit Team**

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| **Lead Auditor** | XXXXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 5 |
| **Technical Experts** | XXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 1 |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 6 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 13 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 1 July 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Summerset by the Lake is owned by the Summerset Group and is currently certified to provide rest home level of care up to 18 residents in the stand alone serviced apartment building. This audit also assessed one more serviced apartment as suitable for a rest home level of care resident. On the day of the audit, there were six rest home residents.The village manager is experienced in aged care management and is supported by a clinical nurse leader. Staff interviewed and documentation reviewed identified that the service has implemented systems that are appropriate to meet the needs and interests of the resident group. Residents interviewed all spoke positively about the care and support provided. |

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| **Outcome 1.1: Consumer Rights** |
| Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family. There are policies around cultural sensitivity and appropriateness with links to an Iwi and kaumatua when required. Residents confirm their spiritual needs are met. Complaints policy and processes align with the code of rights. There have been no concerns or complaints registered in the last year. Residents and family interviewed praised the support and care provided.  |

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| **Outcome 1.2: Organisational Management** |
| Summerset by the Lake has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions. The quality, management and resident/family meetings serve to communicate any quality improvements. There are meetings at all levels to discuss quality data and improvements including the following: health and safety meetings with a focus on falls, infection control; staff meetings (includes all services); management meetings; quarterly resident/family meetings. New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are supported into the position. There is a comprehensive training programme in place with good staff attendance.  |

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| **Outcome 1.3: Continuum of Service Delivery** |
|  The registered nurse undertakes the assessments on admission. The initial support plan is completed within 24 hours of admission.Within three weeks the long term care plan is completed by the registered nurse. The lifestyle care plans are completed comprehensively. The care being provided is consistent with the needs of residents. There is a short-term care plan that is used for acute or short-term changes in health status. Communication with family is documented in the progress notes and care plans. Service delivery plans demonstrate service integration with input from care givers, activities officers, GPs, specialist review and resident and family input where appropriate.Residents are assessed by the general practitioner within 48 hours of admission. Activities are planned that are appropriate to the functional capabilities of resident. Residents interviewed spoke positively about the activities programme. Activities are voluntary. The medication management system includes medication policies and procedures that follow recognised standards and guidelines for safe medicine management practice in accordance with guidelines. Staff responsible for medication administration are trained, and competent.All residents on entry to the service have a nutritional profile developed. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen. The menu is designed and reviewed by a registered dietitian. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
|  Summerset by The Lake is a purpose built facility and is a well maintained home. The service has a current building certificate and maintenance is completed as required. There is enough room throughout the service for residents to mobilise safely. All resident apartments have ensuites. Fixtures, fittings and floor and wall surfaces are appropriate for this environment. Residents rooms are of sufficient space to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise safely. Residents are encouraged to bring in their own furnishings for their rooms. Hot water temperature is monitored monthly at 45 degrees. The service has in place policies and procedures for effective management of laundry and cleaning practices. The service has implemented policies and procedures for civil defence and other emergencies. Regular fire drills are completed and the annual training plan includes emergency training. General living areas and resident rooms are appropriately heated and ventilated. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are documented policies and procedures around restraint use and use of enablers. There are no restraints or enablers in use. |

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| **Outcome 3: Infection Prevention and Control** |
| There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. Infection control training is provided to staff at least annually. All infections are entered into an on-line data base and monthly reports are generated. Infection control is a set agenda for discussion at monthly staff meetings and management meetings. The infection control coordinator has access to the nurse specialist at the District Health Board, general practitioners and other specialists as required. There are policies and procedures in place that reflect current best practice. The programme is approved and reviewed annually and is appropriate to the size and complexity of the service. |

## **Summary of Attainment**

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|  | **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 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a code of rights policy. On interview of staff (two caregivers, one registered nurse/clinical nurse leader and the village manager), all aware of resident rights and are able to describe how they incorporate consumer rights within their service delivery. Five of five rest home residents and one family member interviewed spoke highly of the staff respect of all aspects of the Code of Rights. Code of rights training was attended by 23 staff (across all services including home based support staff) in February 2014. The orientation pack to the service includes training around Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code.  |

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

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

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are posters of the code of rights on display in the main foyer of the facility. Brochures are also available in the main entrance. On entry to the service, residents receive an information pack that includes information around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and a service agreement. Large format and Maori information is also available and posters in English and Maori displayed. Two caregivers who support rest home residents, the clinical nurse leader and the village manager interviewed state that they take time to explain the rights to residents and their family members. On entry to the service, the village manager or clinical nurse leader discusses the information pack with the resident and the family/whānau. This includes the code, complaints and advocacy services.The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. Five of five residents and one family member are able to state their understanding of the code of rights particularly around privacy, respect, complaints. D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, rights information, advocacy and Health and Disability Commission information.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a privacy and dignity policy. Staff are observed respecting resident’s privacy and can describe how they manage maintaining privacy and respect of personal property. All five residents and one family member interviewed indicate that staff are highly respectful and maintained residents privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training occurred in March 2013 (five staff) and May 2014 with 22 staff attending. D4.1a: The resident’s initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly as described by the two caregivers clinical nurse leader and the village manager interviewed. All five resident files reviewed have individual demographic information recorded about residents preferred name and staff are observed speaking respectfully to residents by their preferred name. All residents interviewed can confirm this. There is a spirituality policy. There are various churches locally and residents are encouraged to attend these if possible and as per their choice. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview, two caregivers described how they encourage residents to engage in activities in the facility and to link with community activities including church groups whenever possible. Residents are also encouraged to integrate into the village activities and utilise the village café that has recently opened for socialising and family visits. There is a preventing abuse and neglect policy and the topic is covered at orientation and included in the education planner. There have been no incidents of elder abuse or neglect reported.D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A3.2: The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e) and a Maori health policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policy and plan. The plan and policy have been developed by Summerset in consultation with Maori advisors. A Maori health care plan is put in place for Maori residents. Currently there are no Maori residents. D20.1i: The service is able to access Maori advisors and local iwi advocacy services as identified in the Maori health policy and plan. Discussions with the two caregivers, clinical nurse leader and the village manager confirm they are able to identify how to obtain support so that they could respond appropriately to Maori residents. Cultural safety and Treaty of Waitangi training has been provided to staff as part of the orientation programme in March 2014 (13 staff attended).  |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a cultural awareness policy, which describes the cultural needs of residents. There is a Maori health plan and policy. All five residents interviewed report that they are satisfied that their cultural and individual values were being met. D3.1g: The service provides a culturally appropriate service by carrying out a cultural assessment on admission with family/whānau involvement when available. Family and/or resident is involved in assessment and the care planning process as confirmed on interview. D4.1c: Care plans reviewed (five) include the residents social, spiritual, cultural and recreational needs.Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on.  |

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

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

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a sexual behaviour policy which states there will be zero tolerance against any discrimination occurring. Staff have had sexuality and intimacy training February 2014 (9 staff). The abuse and neglect policy covers harassment and exploitation. All five residents report that staff show respect and there is no evidence of discrimination or coercion. Elderly abuse prevention training occurs at orientation and on a two yearly basis and includes professionalism and standards of conduct. The village manager and clinical nurse leader supervise staff to ensure professional practice is maintained in the service and both are able to describe their role in ensuring that professional boundaries are maintained. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.  |

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

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

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

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

Consumers receive services of an appropriate standard.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies to guide practice that align with the health and disability services standards. There is a quality and risk framework and programme that is being implemented that includes performance monitoring. The caregivers are expected to complete Career Force NZQA level two training as a minimum and an internal in-service training programme is implemented. Across Summerset, quality data benchmarking groups are established for facilities with similar service provision. Summerset by the Lake is currently benchmarked with against one other facility of similar size. The village manager submits the monthly best practice sheet to the clinical and quality manager. Reporting requirements include (but not limited to) meetings held, staffing, quality meeting report, audit conducted and completed with sign off, education provided and quality projects in progress. Reviewed polices are signed off as read by staff. Staff are alerted of policies for reading by time target. Both the village manager (non-clinical) and the clinical nurse leader (RN) attend external training sessions appropriate for their positions |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy, which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident or care/ health issues arises. The family member interviewed stated they are well informed and involved when needed in residents care. D16.4b: All five of five residents and family member interviewed confirm the admission process and agreements documentation were discussed with them. Residents and family state the service provides an environment that encourages open communication. Discussions with two caregivers identified their knowledge around open disclosure and reporting to clinical nurse leader who in turn contacts family. Fourteen of fourteen resident incident/accident forms reviewed identify that the next of kin is contacted.There are resident committee meetings quarterly. The service has policies and procedures available for access to interpreter services and residents (and family) are provided with this information in resident information packs. D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entryD16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Informed consent policies include; informed consent and associated form and a refusal of treatment form, The informed consent form includes medical, liten up (no lifting), transport, purchases and charges. Informed consent information is included in the information pack for new residents. The consent policy includes clear instructions for providing information to residents during the admission process. The clinical nurse leader discussed informed consent processes with residents and their families during the admission process. Five of five residents confirmed that informed consent had been discussed with them. Consent is gained for procedures outside of normal careThere is an advanced directive policy, a not for resuscitation policy and a not for resuscitation authorisation by competent resident form, a not for resuscitation authorisation for incompetent resident form and a resuscitation authorisation form. Completed resuscitation treatment plans and resuscitation advance directive forms were completed on five of five files and they are appropriately signed. The clinical nurse leader is responsible for ensuring consent is gained on admission or as soon as practical. Discussions with two caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Discussions with the village manager, the clinical nurse leader and two caregivers identified that they are familiar with advanced directives and the fact that only the resident (deemed competent) can sign the advance directive.D13.1: There were five admission agreements sighted and all had been signed on the day of admissionD3.1.d: Discussion with a family member identified that the service actively involves them in decisions that affect their relative’s life.  |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an advocacy policy. Staff last received training on code if rights and advocacy services in February 2014. Information about accessing advocacy services is available in the service including advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family with advocacy information. Advocate support is available if requested. Interview with two caregivers, clinical nurse leader, village manager, five residents and a family member confirms that they are aware of advocacy and how to access an advocate.D4.1d; Discussion with five residents identified that the service provides opportunities for them and their family/EPOA to be involved in decisions. D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff state that residents are encouraged to build and maintain relationships. On interview, all residents and family member confirmed this.D3.1h: Discussion with five residents confirm that they are encouraged to be involved with the service and care.D3.1.e: Discussion with staff and residents confirmed that residents are supported and encouraged to remain involved in the community. Visitors are encouraged to attend and utilise the newly opened café during their visits. Five of five residents interviewed confirm their relatives can visit at any time. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information around complaints is provided on admission. Interviews with five of five residents and a family member confirmed an understanding of the complaints process. All staff interviewed including two caregivers and clinical nurse leader are able to describe the process around reporting complaints. The village manager is responsible for the processing concerns and complaints as per complaint procedure. There is a complaints register. There have been no complaints since June 2013 and there is one that has been on-going and being handled by head office. There has not been the need to involve the district health board. Complainants are provided with information on how to access advocacy and Health And Disability Commissioner if resolution is not to their satisfaction and the village manager sends the leaflet as well in the response pack.Discussions with five residents and a family members confirm that they are comfortable in approaching management regarding any concerns they may have. Any complaints received are entered into the Sway (Summerset way) system which also alerts head office. A paper based file is also kept. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset by the Lake provides rest home in serviced apartments for up to 19 residents. On the day of audit there are six rest home residents. Residents currently receiving maximum packages in serviced apartments and requiring higher level of supports are being assessed for rest home care in the serviced apartments. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager. The philosophy, vision and values is documented as part of the quality plan and included in the admission pack.There is a Summerset company business plan 2014, 2014 health and safety plan and an organisational quality and risk improvement plan 2014. All are individualised to Summerset by the Lake. The 2013 plans sighted include review with any on-going goals put into the 2014 plans. The service has made improvements since the previous audit including a focus on team building with monthly lunches, improved attendance at education sessions, the opening of a village café (May 2014) within the facility, completion of external painting and replacement of furniture in the care apartments. Goals for 2014 include registering staff with career force to commence or update qualifications. The service is managed by a non-clinical village manager who holds NZQA management certificate and national certificate in the care of the older person (1994). She maintains an annual medication competency. The village manager attends all clinical training and in-service as well as district health board forums. Monthly teleconferences are held with all village managers of Summerset. Quarterly training days held at head office include human resource management seminars. The village manager is supported by a clinical nurse leader appointed in February 2014. The registered nurse (RN) completed NZ nursing registration competency assessment programme in 2006 and has been working in aged care for seven years. The clinical nurse leader received orientation at another facility under the supervision of the company educator. Summerset provides a comprehensive orientation and training/support programme for their managers. ARC, D17.3di (rest home). The village manager has maintained at least eight hours annually of professional development activities related to managing a rest home.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During the temporary absence of the village manager, the clinical nurse leader undertakes the role of village manager with support from the regional manager. The village manager covers the clinical nurse leader for short periods such as training days and has phone contact with a clinical nurse leader from another site. Medical services are readily accessible. Cover for the clinical nurse leader annual leave is covered by a relieving registered nurse as arranged by Summerset. D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D5.4: The service has up to date policies/ procedures to support service delivery. New or revised policies are available for care staff to read and sign that they have read and understand the changes (policy release folder). Policy and procedure documents no longer relevant to the service are removed and archived. There is a document control programme with reviews dated and documented. There is an organisational quality and risk improvement plan that is documented in 2014 to include quality objectives relative to Summerset by the Lake. The quality programme is reviewed annually (2013 review sighted) and implemented with some goals on-going into 2014. Information is reported through the weekly management meetings (sales manager, officer manager, village manager, clinical nurse leader, activities and property manager), and monthly staff quality meetings. Meeting minutes are sighted with data documented. The monthly quality meeting discusses key components of the quality programme and standing agenda items of the programme include internal audits, infection, accidents and incidents, concerns/complaints and health and safety. Summerset has a data tool "Sway- The Summerset Way" that was launched in 2012 by the organisation. Sway is integrated and accommodates the data entered. The clinical nurse leader analyses all infection control statistics and incidents and accidents monthly which is entered into the Sway system. Graphs and data produced is made available to the staff and reported through meetings at all levels. The data enables the service to benchmark against one other facility of similar size. Reports are documented that include the clinical nurse leader report to the clinical and quality manager and the clinical education manager and the village manager report, which is sent to the operations manager.There are quarterly site health and safety and infection control meetings. The village manager and a senior caregiver have completed NZQA occupational health and safety qualifications and have job description that define health and safety responsibilities. Monthly health and safety checklists are carried out, internal audits (environmental – March 2014, chemical safety – April 2014) and education provided on orientation and on-going (civil defence and emergency management (18 staff) – April 2014, chemical safety April (15 staff) – 2014 and safe manual handling (20 staff) – February2014). All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is reviewed annually. There is an annual internal audit schedule implemented. Corrective actions are documented with evidence of resolution of issues as these are identified. Audit outcomes are linked to meetings at all levels.  D19.3: There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as use of sensor mats, falls risk assessments conducted, physiotherapy input, and exercise programmes. The service is currently trending times of falls. 2014 goal is to reduce falls and the service has implemented the Vitamin D programme for residents in consultation with the residents GP. The annual resident survey (including feedback on personal cares, staff, meals and activities) was conducted in October 2013. The results are collated onto an analysis and action plan. The survey outcome was reported to staff (as minuted) in the December 2013 staff meeting. A food services survey in April 2014 identified concerns around the temperature of food and flavours of food. Consultation meetings were held between the village manager and medirest chef which resulted in a review of the menu. Residents interviewed report a high level of satisfaction in the meals. An activities survey is in progress. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the clinical nurse leader for clinical incidents and accidents and the village manager for non-clinical accident/incidents reports. More serious events are to be entered into the Sway system within 24 hours. Incidents are discussed at all meetings including quality, health and safety and staff meetings monthly and discussed at the clinical quality meetings at head office monthly.The clinical and quality manager analyses all infection control statistics and incidents and accidents are graphed monthly with discussion at the quality meeting.Discussion with the village manager indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. There have been no outbreaks or serious incidents. The appropriate authority was notified with the appointment of the clinical nurse leader. All 14 clinical incident/accident forms (March – one, April – six, May – seven) reviewed included appropriate clinical follow up by the clinical nurse leader. One incident reported for gas leak in the village was addressed promptly by the village manager.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are comprehensive human resources policies as part of the policy manual, this includes job descriptions. There are employment guidelines and templates, which include application form, interview questionnaire, reference check forms and standard letter for employment. Recruitment and employment is completed by the village manager. Senior roles are recruited by the operations manager, the village manager and a member of the head office.  Five of five staff files reviewed (one clinical nurse leader, one property manager, one activity co-ordinator and two caregivers) indicate that all have a documented contract signed by the employee and employer, orientation, application, police check, training records, a current annual practicing certificate if required and referee checks. Annual practicing certificates are documented and filed for other health professionals working in the service. There is a training policy and implemented training programme for staff that includes the provision of compulsory subjects and clinical education. The 2013 training programme as not well attended however there has been an improvement in attendance numbers for all of 2014 training and education to date. Orientation of caregivers includes completion of stage one Career force and all who have not got this already are expected to start this as soon as they have completed orientation with the intention that they complete this within six months. There is a three week post commencement review and follow-up meeting. There is a three to four day orientation period. A performance review is completed three months after employment and annually thereafter. Competencies are completed as relevant to the role. Staff interviewed are able to describe their roles as per their job description. The clinical nurse leader has completed InterRAI training.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery.Care staff including the village manager, clinical nurse leader and two caregiver’s state that staffing levels and the skill mix is appropriate and safe for rest home level residents in serviced apartments. All five residents interviewed advise that they felt there is sufficient staffing. The staffing policy includes two caregivers on site on the morning, afternoon and night shifts. The village manager is on site Monday to Friday. The clinical nurse leader is on duty during the morning shift, works two weekends per month and available on call. There is an additional caregiver shift 7am – 1pm when there is no clinical nurse leader on in the weekend. A short afternoon (5-9pm) caregiver is on duty in the afternoons. The service employs 13 staff including the following: one village manager, one clinical nurse leader, one registered nurse, caregivers, recreational co-ordinator, and administration staff. There are two village staff (caregivers) who deliver personal cares as assessed for village residents. The rest home staff respond to call-outs after hours and all call-outs and/or incidents are recorded. A car is provided for staff to attend call-outs. Medirest provides staff for food services as part of their contract. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate). All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home setting. Summerset by the Lake has a policy and process that describes the control of documents and records that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured room. Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible, dated and signed with designation.  |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission to services there is an assessment of residents and this was evidenced in all five resident files reviewed.Five of five residents and one family/whanau member interviewed all stated that they receive adequate information on admission to the service. There is a well-developed information pack which includes advocacy, health and disability information, fees - where applicable, recreation services, menus and services available.There is a care facility - resident admission and orientation policy and procedure in place.The service has a comprehensive admission policy including information gathered at admission is retained in resident’s records.Five of five residents state they were given an information pack when viewing the facility and were able to discuss the admission process with the village manager and clinical nurse leader. D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.D14.1: Exclusions from the service are included in the admission agreement.D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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

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

ARHSS D4.2

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The reason for declining service entry to residents is recorded and advised should this occur it is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.2, 3, and 4: The clinical nurse leader (RN) undertakes the assessments on admission. The initial support plan is completed within 24 hrs of admission in five of five files sampled. Within three weeks the long term care plan is completed by the clinical nurse leader as sighted in the five files sampled. There is documented evidence that the care plans are reviewed by the clinical nurse leader and is amended when current health changes. Two of the five care plans sampled have been evaluated within six months. The other three residents have not been at the service for six months. Activity assessments and activities care plans are completed by the activity coordinator in all files reviewed. D16.5e: All five resident files sampled identified that the general practitioner had seen the resident within two working days. It was noted in the five resident files reviewed that the general practitioner has assessed the resident as stable and is to be seen three monthly. More frequent GP visits occur for those residents with more complex needs or changes to health status. The GP (interviewed) is impressed with the clinical manager (RN) and states that she keeps him up to date with the needs of the residents either by phone or fax. She triages the residents well and her documentation to him is very comprehensive. The GP is complimentary about the care his residents receive. Two caregivers (who worked the morning shift) and the clinical nurse leader (interviewed) describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are written every shift by caregivers or more often if there are any changes. The clinical nurse leader records concerns and clinical assessments in the progress notes. All five resident files identify integration of allied health personnel and a team approach is evident.Tracer Methodology rest home:     *XXXXXX This information has been deleted as it is specific to the health care of a resident.* .  |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The initial support plan is developed with information from the initial assessment. The registered nursing assessment includes; communication, mental status, mood, bathing and dressing, nutrition, sleep patterns, skin integrity, eating, elimination, UTI's, respiratory and cardiovascular and bowel management. This assessment tool is updated six monthly for each resident as sighted in two of five files sampled where the resident has been at the service longer than six months. The other three files sampled were for residents who have not been at the service for six months.Risk assessment tools and monitoring forms are available and implemented and are used to effectively assess level of risk and required support for residents including (but not limited to); resident mobility scale, safe handling, Braden, falls, continence and diet.. Two of five files sampled identifies the resident has behaviours that challenge. These files contain a behaviour assessment and related plan. Additional assessments were noted such as the Bristol stool chart and cultural assessments. Continuing needs/risk assessments are carried out by the clinical nurse leader. Needs outcomes and goals of residents are identified and these link to care plans including falls assessments, continence care and diet.Five of five files sampled contain all relevant assessments and these are current. Five of five residents and one of one family/whanau interviewed report having been involved in the assessment process. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five resident care plans are reviewed for this audit. Assessment tools relevant to a specific area of the support plan are completed. Residents' files include; daily progress notes, recordings - bowel and fluid charts, family contact record, short term care plans/wounds, long term care plans, risk assessments/nutrition, care plan evaluations, multidisciplinary review (MDT), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes as appropriate.Service delivery plans (lifestyle care plans) demonstrate service integration and demonstrate input from allied health including physiotherapy, GPs and podiatrist where relevant. Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) and progress notes are maintained by the clinical nurse leader and the caregivers.Care plans are comprehensive and well written in five of the five files sampled. D16.3k:Short term care plans are in use for changes in health status.D16.3f: Five of five files identified that family/whanau were involved. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset by the Lake provides services for residents requiring rest home care. The care being provided is consistent with the needs of residents. The lifestyle care plans are completed comprehensively. The care being provided is consistent with the needs of residents; this is evidenced by discussions with the two caregivers, the clinical nurse leader and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.Five of five care plans reviewed are well written, comprehensive and appropriate language for care givers.Five resident’s files are sampled. All five residents had activity of daily living (ADLs) and nutrition well documented. The progress notes all document that the RN has reviewed progress notes weekly and followed up any outstanding problems identified. Two of two residents who experienced unwitnessed falls have been assessed by the RN and had neurological observations completed and documented. Incident/accident forms are completed, family/whanau contacted, and progress notes written. The GP has been contacted. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.Specialist continence advice is available as needed and this could be described.Continence management in-services and wound management in-service have been provided.There are four residents with wounds. One of these wounds is a Grade one pressure area and two are skin tears and one is a scratch. All of these have an associated short term care plan which includes a wound assessment and management plan. All four wounds have been reviewed and evaluated in the stated timeframe. The clinical nurse leader interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.  |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities coordinator has been employed since February 2014 and works 36 hours per week. The service has an activities programme that is well established. Rest home residents are part of the activities programme currently being provided to the serviced apartments. The activities programme is developed by the activities coordinator and each resident receives a copy of the monthly plan. The plan is easy to read and colourful and can be printed in large type to assist those residents with who are visually impaired. Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in crafts, and an exercise programme. There is also reminiscing, music, art, entertainment, themed activities and a variety of activities to maintain strength and interests. There are frequent outings including community events, shopping trips (which residents enjoy and request) and a monthly cafe outing. Residents can now access a cafe which has opened on the premises. Five of five resident files sampled evidenced an individualised assessment document, social history and previous interests and an activity plan. Monthly progress notes are written in five resident files reviewed.D16.5d: Two of five activity plans have been evaluated at the same time as the care plan review. Three activity plans are not due for review. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is evidence of resident and family /whanau (where appropriate) involvement in the review of support plans. D16.4a: Two of the five care plans sampled have been evaluated within six months. The other three residents have not yet been at the service for six months and have not required a care plan evaluation. One of five files sampled indicate that the care plan has been updated when needs change. There are short term care plans to focus on acute and short-term issues. These are evaluated at regular intervals. Changes to the long term lifestyle care plan are made as required. ARC D16.3c: All initial care plans are evaluated by the registered nurses within three weeks of admission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care.D 20.1: Discussions with the clinical nurse leader identified that the service has access to (but not limited to); speech language therapist, physiotherapist, diabetes nurse, wound care nurse, needs assessment co-ordinators and geriatrician. Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.  |

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

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

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

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

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

ARC D21 ARHSS D21

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family/whanau is made. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, the Ministry of Health Medicines Care Guide for Residential Aged Care 2011.The facility uses monthly supplied blister medication packs. Medications are checked on arrival at the facility by the clinical nurse leader. All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily. Seven resident (service has a total of seven residents for rest home care) medication charts were reviewed and all are identified with photographs and are current. There is no transcribing and all seven medication charts sighted have been signed correctly. Seven of seven medication charts have correct charting for prn medications with indications for use. There is a list of staff with specimen signatures that have been assessed as being competent to administer medications. Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. Weekly stocktakes are documented.The clinical nurse leader (interviewed) is conversant with the service medicine management policies and procedures. Caregivers that are responsible for medications undergo an annual competency review.There is a self-medicating resident’s policy available to guide staff practice if required. There are currently no residents self-administering medicines.Medication audits occur annually. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Medication and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified in resident and family interviews.D16.5.e.i.2; Three medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Four medication charts were not due for review. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a large kitchen and all food is cooked on site by contractors. There is a chef employed Monday to Friday and a weekend cook. The service is overseen by a Compass Medirest Unit Manager. On admission the clinical nurse leader completes a dietary profile and communicates individual resident’s needs to the kitchen staff. This information is updated as required. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process. On interview the chef is aware of resident’s likes and dislikes and special dietary preferences.There is a daily cleaning schedule in place.There is a comprehensive kitchen manual in place. The menu has been reviewed by a dietitian.The fridge and freezer temperatures are monitored daily and are within acceptable limits (sighted). Hot food temperatures are recorded at lunch and dinner.All food in the fridge and pantry is dated and labelled. Meat was noted to be stored correctly and the kitchen is clean. Protective clothing is available including hats, gloves and aprons.Five of five residents and one of one family/whanau report a high level of satisfaction with meals.D19.2: All staff working in the kitchen have food handling certificates and receive on-going monthly training from Compass.  |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets available throughout the facilities and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Equipment is sighted in sluice rooms and the laundry. Gloves are available in all ensuites and there are plentiful supplies of gowns on caregiver’s trolleys. Clothing is provided and used by staff. Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The electronic database provides evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. The property manager (interviewed) is responsible for the assets, grounds and gardens, vehicles, maintenance and repairs for the care centre and village. Planned and reactive maintenance systems are in place. Staff use a maintenance request book which is sighted daily and addressed. Medical equipment is calibrated annually. The hoist required a functional test and this was arranged on the day of audit. Hot water temperatures are monitored monthly and are between 43 – 45 degrees Celsius. Each apartment has a tempering valve. There is a current Building Warrant of Fitness that expires on November 2014. Electrical testing and tagging of equipment is current. A visual Inspection of the facility provides evidence of safe storage of medical equipment. Corridors are wide enough in all areas to allow residents to pass each other safely with safety rails appropriately located. The internal and external areas are safely maintained and are appropriate to the resident group and setting and include outdoor seating and shade. Residents interviewed confirm they know the process should they require any repairs/maintenance and that these requests are actioned within a reasonable timeframe. Family/whanau and residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.ARC D15.3: The village manager, clinical nurse leader and two caregivers interviewed confirm that they have access to appropriate equipment including: electric beds, shower chairs, hoist and lifting aids, mobility aids, pressure area mattress and floor scales. There is a call bell in each bedroom and ensuite. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Each resident rooms (apartments) have their own en-suite that includes a shower, toilet and hand basin. There is also a communal toilet available. Visual inspection evidences the en-suite facilities are of appropriate design with fixtures, handrails and non-slip flooring. There are paper towels and hand towels available in the en-suites. The toilets have appropriate access for residents based on their needs and abilities and meet specifications for people with disabilities. They are spacious enough for easy manoeuvre of mobility aids and where practicable, provide adequate working space for staff. This includes the bathroom in the one serviced apartment being approved for rest home level care. Hot water temperatures are being monitored in resident areas and records were sighted.  |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Visual inspection evidences that adequate personal space is provided in all apartment bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff, residents and family. The bedroom in the one additional serviced apartment being approved for rest home level care is spacious enough to provide rest home level and manoeuvre transferring equipment/mobility aids as required.  |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Adequate access is provided to lounge, dining and other communal areas and residents are able to move freely within these areas. Family/whanau and residents interviewed confirm there are alternate areas available to them for visitors or attending activities. There is a newly opened café where residents can enjoy time with family/friends. All apartments have a lounge/dining area.  |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is well managed and dirty to clean flow is evident. All laundry and cleaning is completed onsite by staff. There are covered linen trolleys used by the caregivers. The resident annual satisfaction survey includes laundry services and the service is audited annually. Laundry and cleaning are a seven day service. Cleaning cupboards are sighted and locked. Chemicals are labelled and safely stored. A chemical supplier provides a closed chemical system for the laundry and monitors the effectiveness of chemicals. Residents and family/whanau interviewed report satisfaction with the cleaning and laundry service.  |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors. There are security gates to the complex which are linked to the staff pager system for afterhours access. Letters from New Zealand Fire Service reviewed dated 16 August 2000 advising approval of fire evacuation schemes. The last trial evacuation was held in May 2014. Staff interviews and review of files provides evidence of current training in relevant areas. There is a first aider on duty at all times. Emergency and security situation education is provided to service providers during their orientation phase. This includes fire safety training and emergency security situations. Civil defence training was attended by 18 staff in January 2014. There are emergency flip charts located within staff areas. The service is planning a civil defence exercise in the village with police and emergency services involvement. Emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; A visual inspection of the facility evidences: emergency lighting, torches, civil defence bin, adequate food supplies, emergency water supply, gas barbeque and gas bottles. There is a three hour battery back-up for emergency lights and the call bell system. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ensuite toilet/showers, the lounge and dining room. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The main heating is central heating and the main lounge also contains a large electric wall heater. There is a designated external smoking area.Family/whanau and residents interviewed confirm the facilities are maintained at an appropriate temperature. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff. The restraint co-ordinator (registered nurse) is able to describe the role and responsibilities and there is a job description of the restraint coordinator.There are no restraints or enablers in use. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control nurse is a registered nurse (clinical nurse leader) who has had previous experience in an infection control role prior to employment at Summerset by the Lake. The infection control coordinator is supported by the village manager, clinical and quality manager at head office and education and nurse manager. The infection control programme is appropriate for the size and complexity of the service. There are site specific quality goals included in the infection control programme. The programme is approved and reviewed annually by the infection control coordinator through the monthly quality staff meetings and the weekly management meetings. There is a job description for the infection control coordinator including the role and responsibilities. There have been no outbreaks. Visitors are requested to not to visit if they have been unwell or in contact with people with vomiting or diarrhoea. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator provides an infection control report to the monthly quality staff meetings (minutes sighted). The infection control coordinator can access external specialist advice from doctors, laboratories, other Summerset infection control nurses and the District Health Board infection control specialists/gerontologists when required. The infection control coordinator states that there is access to all relevant resident information to undertake surveillance, audits and investigations. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset by the Lake has infection control policies and an infection control manual, which reflect current practise. D 19.2a: Infection control policies include hand hygiene, standard precautions, transmission-based precautions, outbreak management, antimicrobial usage, prevention and management of infections.The infection control policy was reviewed last in January 2013.  |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator is scheduled to attend infection prevention and control seminar at the district health board in September 2014. Staff complete annual infection control education. Standard precautions was attended by nine staff in May 2013 and pandemic health plan was attended by 18 staff in March 2014. Hand hygiene audits were completed in March 2014. Infection control is a set agenda item at staff meetings and in-service is also provided at the time of staff meetings. The training folder records the staff education session content and attendance records. External resources, including DHB, laboratory, other Summerset IC nurses and general practitioners ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery.  |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the infection control coordinator who has an understanding of infection surveillance. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset by the Lake are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and infection information is entered into the Summerset (Sway) database, which generates a monthly analysis of the data. The analysis, trends and quality improvements are reported to the staff meetings. Communication between the facility’s primary and secondary services regarding infection control is reportedly responsive and effective as stated by the clinical nurse leader. The general practitioner (interviewed) confirmed that staff provide information about any changes in state for a resident including suspected infections (as per the clinical indicators for infection) confirms that instructions are followed up. There is evidence of general practitioner involvement and laboratory reporting in the resident files reviewed. Short term care plans are in place for infections. |

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

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

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

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

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

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