# Pembrey Investments Limited

## Current Status: 10 June 2014

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

## General overview

Brooklands village rest home is privately owned and operated and is certified to provide rest home level care for up to 36 residents with full occupancy on the days of audit. The rest home is managed by an enrolled nurse who has been in the role for 25 years. She is supported by a part time registered nurse and care staff. The service has a quality and risk management programme in place which requires further improvement. Quality activities are conducted to identify opportunities for improvement in service provision. Residents and families interviewed reported that they are very satisfied with the care and support provided.

This certification audit identified that improvements are required in relation to, review of resuscitation orders, policy review, clinical input following incidents, conducting annual appraisals for staff, aspects of education programme, aspects of care planning relating to timeframes, conducting assessments, documenting family involvement, recording of interventions and use of short term care plans, also dating decanted foods and dietitian review of the menu.

## Audit Summary as at 10 June 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | 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 10 June 2014

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

### Organisational Management as at 10 June 2014

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

### Continuum of Service Delivery as at 10 June 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 10 June 2014

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

### Restraint Minimisation and Safe Practice as at 10 June 2014

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

### Infection Prevention and Control as at 10 June 2014

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

## Audit Results as at 10 June 2014

### Consumer Rights

The support provided to residents at Brooklands village rest home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is appropriately documented. Improvements are required in relation to resuscitation orders. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

### Organisational Management

Brooklands village rest home has an organisational philosophy, which includes a vision, mission statement and strategic objectives.

The facility is privately owned with a manager (enrolled nurse) employed to run the home on a day to day basis. The manager is supported by the owners, a registered nurse and care staff. The facility is guided by a set of policies and procedures, some of which require review. An internal audit programme monitors service performance. Corrective actions are developed and followed through where performance has been identified as less than expected. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction programmes for the staff ensure staff are competent to provide care. Improvements are required around provision of all educational requirements. Staffing levels are safe and appropriate. Improvements are also required in relation to ensuring that all employees have annual appraisals conducted.

### Continuum of Service Delivery

The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney. An assessment, including a variety of risk assessments is intended to be completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans, communication with family documented. There are improvements required around timely review by the registered nurse, assessments, family involvement in care plan reviews, interventions, short term care plans and wound management

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned weekly.

The service has transfer and discharge procedures with are understood by staff.

Medicine management policies and procedures detail service provider's responsibilities. A registered nurse, an enrolled nurse and the senior health assistants are responsible for medicine management. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around staff administration, staff documentation, transcribing, staff competency assessments, assessments of competency for residents who self-administer medicines, safe storage of resident’s medications self- administrating and three monthly reviews by the GP.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. There is an improvement required around review of the menu by a dietitian and dating of decanted foods. Residents and families interviewed all confirmed satisfaction with food services

### Safe and Appropriate Environment

The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has vans available for transportation of residents. Those transporting residents hold a current first aid certificate. There is a large spacious lounge and dining areas and other smaller lounges. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is managed onsite. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference.

### Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

### Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Pembrey Investments Limited |
| **Certificate name:** | Pembrey Investments Limited |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Brooklands Retirement Village |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 10 June 2014 | **End date:** | 11 June 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 36 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 12 | Total audit hours | 36 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 11 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 29 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, 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:

|  |  |  |
| --- | --- | --- |
| 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 Monday, 7 July 2014

## **Executive Summary of Audit**

**General Overview**

Brooklands village rest home is privately owned and operated and is certified to provide rest home level care for up to 36 residents with full occupancy on the days of audit. The rest home is managed by an enrolled nurse who has been in the role for 25 years. She is supported by a part time registered nurse and care staff. The service has a quality and risk management programme in place which requires further improvement. Quality activities are conducted to identify opportunities for improvement in service provision. Residents and families interviewed reported that they are very satisfied with the care and support provided.

This certification audit identified that improvements are required in relation to, review of resuscitation orders, policy review, clinical input following incidents, conducting annual appraisals for staff, aspects of education programme, aspects of care planning relating to timeframes, conducting assessments, documenting family involvement, recording of interventions and use of short term care plans, also dating decanted foods and dietitian review of the menu.

**Outcome 1.1: Consumer Rights**

The support provided to residents at Brooklands village rest home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is appropriately documented. Improvements are required in relation to resuscitation orders. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

**Outcome 1.2: Organisational Management**

Brooklands village rest home has an organisational philosophy, which includes a vision, mission statement and strategic objectives.
The facility is privately owned with a manager (enrolled nurse) employed to run the home on a day to day basis. The manager is supported by the owners, a registered nurse and care staff. The facility is guided by a set of policies and procedures, some of which require review. An internal audit programme monitors service performance. Corrective actions are developed and followed through where performance has been identified as less than expected. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction programmes for the staff ensure staff are competent to provide care. Improvements are required around provision of all educational requirements. Staffing levels are safe and appropriate. Improvements are also required in relation to ensuring that all employees have annual appraisals conducted.

**Outcome 1.3: Continuum of Service Delivery**

The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or enduring power of attorney. An assessment, including a variety of risk assessments is intended to be completed on admission and reviewed six monthly following admissions. Residents and/or family have input into the development of care plans, communication with family documented. There are improvements required around timely review by the registered nurse, assessments, family involvement in care plan reviews, interventions, short term care plans and wound management

Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. Residents' files evidence activity care plans included in the long term care plan identify goals, and interventions and are evaluated at least six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned weekly.

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Medicine management policies and procedures detail service provider's responsibilities. A registered nurse, an enrolled nurse and the senior health assistants are responsible for medicine management. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are improvements required around staff administration, staff documentation, transcribing, staff competency assessments, assessments of competency for residents who self-administer medicines, safe storage of resident’s medications self- administrating and three monthly reviews by the GP.

A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. All food is cooked on site and kitchen staff have attained safe food handling certificates. There is an improvement required around review of the menu by a dietitian and dating of decanted foods. Residents and families interviewed all confirmed satisfaction with food services

**Outcome 1.4: Safe and Appropriate Environment**

The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. The facility has vans available for transportation of residents. Those transporting residents hold a current first aid certificate. There is a large spacious lounge and dining areas and other smaller lounges. There are adequate toilets and showers. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is managed onsite. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference.

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

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

**Outcome 3: Infection Prevention and Control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 36 | 0 | 7 | 2 | 0 | 0 |
| **Criteria** | 0 | 82 | 0 | 7 | 4 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | Four files did not show evidence of annual review of resuscitation orders as per policy. | Ensure that advanced directives including resuscitation orders are reviewed with in timeframes specified in facility policy. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | i) Admission policy and care plan policy do not align with contractual requirements. The policies state that the rest home manager or registered nurse is responsible for interviewing and assessing the resident on admission and that the RN assesses the new resident on her next working day. As the RN only works Monday to Thursday, there is the potential for residents to be assessed by someone other than an RN and for the assessment to be outside the required timeframes; ii) medication policy does align with current guidelines for medication management. Phone orders policy states that the GP to chart changes at his earliest convenience, rather than within the next two working days. Home remedies policy does not include RN input prior to caregivers administering. There is no PRN policy within the suite of medication management policies to guide care staff in the safe administration of PRN medication. Residents who self-medicate – policy needs to reflect current guidelines in relation to checks conducted by staff. | i)and ii) Ensure all policies and procedures required are developed and implemented and that they reflect current best practice and recognised guidelines and legislation. | 60 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting  | 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.  | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Collation of incident forms and comments by the RN is entered on the computerised incident report at the end of each month. Health assistants are responsible for management of incidents including first aid, care of the resident, phoning the GP if required and emergency care. The senior caregiver on duty is trained on first aid and is experienced in care of the elderly. The manager lives nearby and attends the facility if required. However, on review of incidents for May 2014, it is noted that there is a lack of evidence to confirm that further assessment and follow up of the resident involved is conducted by the registered nurse post incident.  | Ensure that all residents involved in incidents or accidents are reviewed in a timely manner by the registered nurse. | 30 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | i)Safe chemical handling and Treaty of Waitangi training has not been provided in the past two years; ii) on review of education records it is noted that attendance rates and content of education sessions are not always recorded; iii) The registered nurse and manager have not had annual performance appraisals conducted.  | i)Ensure all educational requirements are provided for staff; ii) maintain records of education sessions provided and attendance records; iii) ensure that all employees have annual staff appraisals conducted as per ARC contract. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Two residents with documented health changes did not have a timely review by the RN include: one resident with swollen legs, documented by a health assistant on 22 May 2014, showed no evidence of RN documented review until 27 May 2014 in the progress notes; one resident with documented  pain from the back, knees and shoulder on 7 June 2014 was given analgesia by the health assistant, with no evidence of documented follow up by the RN. There is no documented evidence of family involvement in the six monthly review of five of six files sampled (one resident has not been at the service for longer than six months). | Ensure that residents with health changes have a timely review by a registered nurse. Ensure that there is documented evidence that family are involved in the six monthly review of the care plan as required. | 90 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment  | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low |  Pain assessments were not evidenced as being reviewed six monthly for five of six files sampled or with on-going monitoring recorded for two residents requiring administration of controlled medication as part of prescribed pain management plan.  | Ensure pain assessments are reviewed at least six monthly for all residents and on-going pain monitoring is completed for residents with on-going pain.  | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i) One resident with an indwelling catheter did not have documented evidence of change of catheter. (ii) One resident with bowel difficulties did not have documented interventions in the care plan. (iii) One resident had documented frequency of dressing as required daily on the wound management plan, however this was not evidenced as completed daily. (iv) Two residents with leg oedema and one resident with a urinary tract infection did not have interventions documented in the LTCP (long tern care plan) or a STCP (short term care plan) completed. | (I) and (ii) Ensure that interventions for residents assessed needs are documented in the care plan. (iii) Ensure that wound care is appropriate according to assessment needs. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i) Three out of 12 medication charts sampled had evidence of transcribing by the health assistants and registered nurse. (ii) Seven out of 12 medication charts sampled did not show evidence that inhalers or creams prescribed were signed as given. (iii) Six of twelve medication charts did now show evidence of three monthly reviews by the GP. | (i)Ensure that transcribing ceases. (ii) Ensure that inhalers and creams are administered and signed for as prescribed. (iii) Ensure that the GP reviews the resident medication three monthly and documents this on the computer. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | (i) There is no comprehensive competency assessments completed for staff administrating medications. A medication questionnaire is completed by staff with no further assessment of medication administration competency documented; (ii) two staff observed administrating medications staff did not check the medication with the GP prescription and both signed for medications before they were given to the resident. | (i) Ensure all staff who administers medications have a regular competency assessment conducted. (ii) Ensure that staff administrating medications check with the GP prescription and sign after the medication is taken. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | (i) One of the four residents who self-administer medicines did not keep her drawer locked. (ii) All four residents have not had a competency assessment completed. (iii) One resident on controlled drugs was noted to have taken the wrong days medication on the day of the audit.  | (i) Ensure that all medications are kept in a locked drawer. (ii) & (iii) Ensure self-administration competencies are completed at least three monthly. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | (i) The menu has not been reviewed by a dietitian within the last two years. (ii) Decanted food in the pantry is not dated | (i) Ensure that the menu is reviewed and approved by a dietitian. (ii) Ensure that decanted foods are dated. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (five health assistants, one activities coordinator, one registered nurse, and one manager) confirm their familiarity with the Code. Interviews with six rest home residents and five relatives confirm the services being provided are in line with the code of rights.
Code of rights and advocacy training is provided as a regular in-service education and training topic (last provided in March 2014).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with six residents and five relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.
Two monthly rest home resident meetings (minutes sighted for June 2014) are held providing the opportunity to raise concerns in a group setting. The most recent annual resident satisfaction survey (August 2013) and family satisfaction survey (May 2014) includes questions relating to complaints process and residents rights, with respondents reporting they were overall satisfied or very satisfied.
Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.
D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.
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.
There are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents’ files.
Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All six residents and five relatives confirm the service is respectful.
A resident satisfaction survey and a relative satisfaction survey is carried out annually to gain feedback. Survey questions relating to communication, complaints, care, privacy, respect, and dignity reflect residents and families are either satisfied or very satisfied.

D4.1a: Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family.
The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with six residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Six care plans reviewed identify specific individual likes and dislikes.
The elder abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and last provided in July 2013.
Discussions with the manager and registered nurse report there have been no identified incidents of abuse or neglect.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.
There are no residents at Brooklands village rest home who identify as Maori. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori. The service utilises a Maori advocate on an as-needed basis for consultation. This individual is identified in policy.
Interviews with five health assistants, one registered nurse, and one manager confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Treaty of Waitangi training or cultural training has not been provided in the past two years (link #1.2.7.5).
A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Care planning includes consideration of spiritual, psychological and social needs. Six residents indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Five relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions.
D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.
D4.1c: Six of six care plans reviewed include the residents’ social, spiritual, cultural and recreational needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the manager. Interviews with five health assistants, one registered nurse and one manager acknowledge their understanding of professional boundaries.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that are received. The manager is responsible for coordinating the internal audit programme. The manager is a qualified ACE assessor and facilitates the programme for care staff. There is access to computer and internet resources. Policies and procedures are available in hard copy. There are staff meetings and quality meetings conducted and two monthly resident meetings.
Six residents and five relatives interviewed spoke very positively about the care and support provided. Five health assistants, one registered nurse, and one activities coordinator have a sound understanding of principles of aged care and state that they feel supported by the manager.
A2.2: Services are provided at Brooklands village rest home that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring
D1.3: all approved service standards are adhered to.
D17.7c.There are implemented competencies for health assistants which require improvement. The registered nurse (RN) and manager are required to undergo medication competencies (link 1.3.12.3). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies are in place relating to open disclosure. Six residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.
A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Five relatives interviewed confirm they are notified of any changes in their family member’s health status. The manager and registered nurse can identify the processes that are in place to support family being kept informed.
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 entry.
D16.1b.ii the residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.
D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for two of six files sampled. Four files did not show evidence of annual review as per policy. This is an area requiring improvement. Six files were reviewed and found to have valid consents. It was stated by the registered nurses that family involvement occurs with the consent of the resident. Other forms of written consents included consent to share information, consent for photographs and consent for transportation. A review of six files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Six residents interviewed confirm that they are given good information to be able to make informed choices. Five health assistants and one registered nurse and one manager interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.

D3.1.d Discussion with five families identified that the service actively involves them in decisions that affect their relative’s lives.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Six residents interviewed confirm that they are given good information to be able to make informed choices. Five health assistants and one registered nurse and one manager interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.

**Finding:**

Four files did not show evidence of annual review of resuscitation orders as per policy.

**Corrective Action:**

Ensure that advanced directives including resuscitation orders are reviewed with in timeframes specified in facility policy.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.
Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items.
D4.1e; The residents’ files include information on residents family/whanau and chosen social networks.
Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.
D4.1d; Discussions with five relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident information pack informs visiting can occur at any reasonable time. Interviews with six residents and five relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans.
D3.1.e Discussions with six residents and five relatives verify that they are supported and encouraged to remain involved in the community. Brooklands village rest home support on-going access to community services (e.g. church, general practitioner visits, and library). Entertainers are invited to perform at the facility.
D3.1h: Discussions with five families verify that they are encouraged to be involved with the service and care. Further improvements are required in relation to family input in to care planning (link #1.3.3.4).

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.
Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service.
Interviews with six residents and five relatives are familiar with the complaints procedure and state any concerns or issues are addressed.
The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been five lodged complaints in 2013 and one in 2014. Advised by the manager that full investigations were conducted and resolutions obtained which included staff performance management as required. All communication with the complainants have been documented for the lodged complaints. Advised that resident meetings are an open forum for residents to air any concerns or issues which are then dealt with in a timely manner.
D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Brooklands village rest home provides rest home level care for up to 36 residents with full occupancy in the day of audit. The philosophy of care includes a mission statement and vision. The philosophy of Brooklands village “endeavors to bring together and combine the many talents of retired folk, to continue expressing their individual talents amongst their peers in pursuit towards resident’s physical, mental and spiritual needs” and “dignifies and respects resident’s life-time accomplishments, individual ethnic origins, religion and beliefs so that all groups can join together in companionship to enhance and fully enjoy the many wonderful Village activities”.

The business is privately owned with owners providing accounting and payroll support to the manager. The manager (enrolled nurse) has been in the role for 25 years and is sufficiently experienced. The manager reports to the owners on a weekly basis. The manager attends two monthly aged care provider meetings in Dunedin.
An organisational chart visually describes reporting relationships for the organisation. The service has a business plan for 2011-2015 and a quality plan for 2014. The business plan includes goals which relate to quality care, financial management, occupancy, staff training and quality improvements. The quality plan includes nine standards relating to resident care and services. A risk management plan includes hazard identification and management. Dates for completion are documented with evidence of ongoing monitoring. The internal audit programme regularly assesses service performance and an annual review of the quality programme was conducted in May 2014. The manager is responsible for the quality management system at Brooklands village rest home with support from the registered nurse.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the manager’s absence, the registered nurse is in charge with support from senior care staff and owners. The manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme. The manager works full time and the registered nurse works 25 hours per week. The manager covers the majority of the on-call component with the RN available for second on call and alternate weekends.
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The quality and risk management system is understood and implemented by the manager, registered nurse and staff. Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan for 2011-2015 and a quality plan for 2014. The business plan includes goals which relate to quality care, financial management, occupancy, staff training and quality improvements. A risk management plan includes hazard identification and management. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance and an annual review of the quality programme was conducted in May 2014. The quality plan includes nine standards relating to resident care and services including (but not limited to) providing a home-like environment, ensuring respect, dignity and privacy for each resident, maintaining independence, supporting the resident in maintaining optimal physical and mental health, activities, safety and quality of life. The internal audit programme regularly assesses service performance and this is also discussed at the two monthly quality assurance and risk management meetings. Annual review of the 2013 quality plan was conducted in May 2014. A resident survey was conducted in August 2013 and a family survey was conducted in May 2014. Comments were very positive. Questions relate to communication, complaints management, care, privacy, respect, dignity, clinical and medical care, laundry, meals, activities and cleaning. Overall, responses in all areas as either satisfied or very satisfied.

A set of policies and procedures are in place to guide staff. The registered nurse and manager report new and/or revised policies are developed with input from staff. The manager signs off on all new policies. They are available for staff to read and to sign after reading.
Policies and procedures are stored in hard copy files at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. On review of the clinical policy manual it is noted that policies relating to admissions, care planning and medication management require review to ensure they are in line with contractual requirements and current guidelines. Improvements are required in these areas.
On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the audits are being completed as per the audit schedule. Internal audit outcomes are reported to the staff and quality assurance/risk management meeting (minutes sighted for 3 June 2014).
Corrective actions have been developed for audits, surveys and meeting minutes and there is evidence to confirm that these have been completed, evaluated and signed off. Verbal discussion is held at the staff and quality assurance meetings regarding quality activities, as evidenced in meeting minutes. Opportunities for improvement are identified through the various quality activities and corrective actions are recorded and completed. Results of the resident and family satisfaction survey have been discussed with the residents in the two monthly residents/family meetings (minutes sighted for June 2014). Meeting minutes for all meetings are posted in the staff room.
Incidents and accidents are reviewed monthly by the registered nurse with analysis and corrective actions detailed on the electronic incident report. However, timely review of individuals post incident is not well evidenced (as per finding #1.2.4.3).
Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).
D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.
D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident an hazard management
D19.2g Falls prevention strategies include closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercises.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A set of policies and procedures are in place to guide staff. The registered nurse and manager report new and/or revised policies are developed with input from staff. The manager signs off on all new policies. They are available for staff to read and to sign after reading.
Policies and procedures are stored in hard copy files at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. On review of the clinical policy manual it is noted that policies relating to admissions, care planning and medication management require review to ensure they are in line with contractual requirements and current guidelines.

**Finding:**

i) Admission policy and care plan policy do not align with contractual requirements. The policies state that the rest home manager or registered nurse is responsible for interviewing and assessing the resident on admission and that the RN assesses the new resident on her next working day. As the RN only works Monday to Thursday, there is the potential for residents to be assessed by someone other than an RN and for the assessment to be outside the required timeframes; ii) medication policy does align with current guidelines for medication management. Phone orders policy states that the GP to chart changes at his earliest convenience, rather than within the next two working days. Home remedies policy does not include RN input prior to caregivers administering. There is no PRN policy within the suite of medication management policies to guide care staff in the safe administration of PRN medication. Residents who self-medicate – policy needs to reflect current guidelines in relation to checks conducted by staff.

**Corrective Action:**

i)and ii) Ensure all policies and procedures required are developed and implemented and that they reflect current best practice and recognised guidelines and legislation.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Adverse events (including but not limited to: falls, skin tears, behaviours, infections, medicine errors) are documented on an incident form on the computerised resident management system by the person witnessing the event. On review of incidents for May 2014, there is a lack of evidence to confirm that further assessment and follow up of the resident involved is conducted in a timely manner by the registered nurse. Improvements are required in this area. Data is collected and collated on a monthly basis by the registered nurse and reported to the quality assurance meeting. Staff have access to these meeting minutes. Results are also communicated to staff at the staff meetings (meeting minutes sighted).

A sample of nine incident forms were reviewed for May 2014 and involved five residents. Incidents reviewed included one resident with two falls, one resident with three falls, one resident with a skin tear and a fall, one resident with a fall and a dislocation and one resident with a fall and an infection. Staff advised that they document family being contacted and write a description of the event in the resident’s computerised daily notes (viewed for all five residents with related incidents). Adverse events include an investigation by the RN at the end of the month. Advised that follow up is conducted by the manager or registered nurse and GP is notified if required. The incident report records the response by health assistants and what actions were taken - including a monitoring of the resident post fall, neurological observations and wound care. The incident reports are completed and a printed copy is signed by the caregiver completing the report. There is a lack of evidence of RN review of the resident post incident.

Statutory and regulatory obligations are understood by the manager and registered nurse. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.
D19.3b; there is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Adverse events (including but not limited to: falls, skin tears, behaviours, infections, medicine errors) are documented on an incident form on the computerised resident management system by the person witnessing the event. Data is collected and collated on a monthly basis by the registered nurse and reported to the quality assurance meeting. Staff have access to these meeting minutes. Results are also communicated to staff at the staff meetings (meeting minutes sighted).

A sample of nine incident forms were reviewed for May 2014 and involved five residents. Incidents reviewed included one resident with two falls, one resident with three falls, one resident with a skin tear and a fall, one resident with a fall and a dislocation and one resident with a fall and an infection. Staff advised that they document family being contacted and write a description of the event in the resident’s computerised daily notes (viewed for all five residents with related incidents). Adverse events include an investigation by the RN at the end of the month. Advised that follow up is conducted by the manager or registered nurse and GP is notified if required however, this could not be confirmed. The incident report records the response by health assistants and what actions were taken - including a monitoring of the resident post fall, neurological observations and wound care. The incident reports are completed and a printed copy is signed by the caregiver completing the report.

**Finding:**

Collation of incident forms and comments by the RN is entered on the computerised incident report at the end of each month. Health assistants are responsible for management of incidents including first aid, care of the resident, phoning the GP if required and emergency care. The senior caregiver on duty is trained on first aid and is experienced in care of the elderly. The manager lives nearby and attends the facility if required. However, on review of incidents for May 2014, it is noted that there is a lack of evidence to confirm that further assessment and follow up of the resident involved is conducted by the registered nurse post incident.

**Corrective Action:**

Ensure that all residents involved in incidents or accidents are reviewed in a timely manner by the registered nurse.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There are 29 staff employed by Brooklands village rest home which includes a manager, a registered nurse, health assistants, kitchen staff, cleaning and laundry staff and activities staff. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurse and general practitioners.
Six staff files were randomly selected for review (one registered nurse, one manager, two health assistants, one trainee chef and one activities coordinator/caregiver). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, and evidence of a completed orientation programme. Medication competencies are conducted for senior care givers who have responsibility for administering medications. This includes the completion of a medication questionnaire but does not a detailed observation of practice There are no competencies for assessing administering PRN medication or controlled drugs, blood sugar monitoring or insulin administration (link #1.3.12.3). Police checks are not routinely conducted for new staff. Annual appraisals have been completed for three of six staff – one has been employed within the past 12 months. The registered nurse and manager have not had annual performance appraisals conducted.
Brooklands village rest home has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed care givers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for two recently employed health assistants and one trainee chef). Interviews with five health assistants confirm their orientation to the service was thorough. Staff files reviewed reflected evidence of an orientation programme that had been completed.
A system is in place to identify, plan, facilitate and record on-going education for staff. The education programme for 2012- 2014 included the following: elder abuse, vision impairment, infection control, cultural awareness, wound care, food handling, challenging behaviour management, observations and documentation, first aid, continence, medication management, code of consumer rights and advocacy. Safe chemical handling and Treaty of Waitangi training has not been provided in the past two years. Improvements are required in this area. A compulsory two hour annual staff training session is also held and includes sessions on basic cares, observations, blood sugar level monitoring, fire safety and civil defence, infection control, safe manual handling, pressure area care, food safety and wound care. The registered nurse attends off site education and has attended infection control training. On review of education records it is noted that attendance rates and content of education sessions are not always recorded. Improvements are required in this area. The ACE care giver training programme is provided at Brooklands village rest home and is coordinated by the manager. All caregivers are encouraged to complete the course. Fire drill was last conducted on 11 March 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A system is in place to identify, plan, facilitate and record on-going education for staff. The education programme for 2012- 2014 included the following: elder abuse, vision impairment, infection control, cultural awareness, wound care, food handling, challenging behaviour management, observations and documentation, first aid, continence, medication management, code of consumer rights and advocacy. A compulsory two hour annual staff training session is also held and includes sessions on basic cares, observations, blood sugar level monitoring, fire safety and civil defence, infection control, safe manual handling, pressure area care, food safety and wound care. The registered nurse attends off site education and has attended infection control training. The ACE care giver training programme is provided at Brooklands village rest home and is coordinated by the manager. All care givers are encouraged to complete the course. Fire drill was last conducted on 11 March 2014. Annual appraisals have been completed for three of six staff – one has been employed within the past 12 months.

**Finding:**

i)Safe chemical handling and Treaty of Waitangi training has not been provided in the past two years; ii) on review of education records it is noted that attendance rates and content of education sessions are not always recorded; iii) The registered nurse and manager have not had annual performance appraisals conducted.

**Corrective Action:**

i)Ensure all educational requirements are provided for staff; ii) maintain records of education sessions provided and attendance records; iii) ensure that all employees have annual staff appraisals conducted as per ARC contract.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A recruitment and orientation policy is in place that includes a documented rationale for staffing the service. Staffing rosters were sighted. Part time staff fill casual shifts. The registered nurse works four days per week and the manager works full time Monday to Friday. The manager covers the bulk of after hour’s on-call with the registered nurse on call for one week end every fortnight. Advised that the RN can be contacted at other times as required. There is further support from general practitioners and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by manager, and registered nurse. Roster includes a mixture of short and long shifts on each shift with a minimum of two health assistants on duty overnight. The kitchen is staffed by a chef and trainee cook and kitchen hands. Activities are provided by an activities coordinator and there are designated laundry and cleaning staff. Maintenance is completed by a designated maintenance person.
Staff turnover is reported by the manager as low. Staffing levels are altered according to resident numbers and acuity.
One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.
Six residents and five relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents' paper files are protected from unauthorised access by being locked away in the nurses’ stations and staff must log on to access the computerised resident information system prior to making entries. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
D7.1 entries in the computerised programme such as daily records and wound care, are automatically dated and the name and designation of the person making the entry is recorded as evidenced in files reviewed.
There are paper based individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry to Brooklands Village rest home potential residents have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and resident information available for residents/families at entry. The information includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The admission policy describes the declined entry to services process. Brooklands Village rest home records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. The manager reports that entry to the service would only be declined if there were no beds available or the resident is not appropriately assessed for rest home level care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

D16.2, 3, and 4: The six resident files reviewed identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurse. Two residents with documented health changes did not have a timely review by the registered nurse. This is an area requiring improvement. Five of six care plans evidenced evaluations completed at least six monthly. One resident has not been at the service longer than six months. Activity assessments and the activities sections in care plans have been completed by the activity coordinator (DT). Six residents interviewed stated that they and/or their family were involved in planning their care plan.

D16.5e: All resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP reviews were evidenced as occurring on review of resident’s files with acute conditions.

Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery (observed). Six files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurse and the manager consult with the GP with any concerns regarding residents’ health status and he believes the service provided meets resident’s needs.

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery (observed). Six files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurse and the manager consult with the GP with any concerns regarding residents’ health status and he believes the service provided meets resident’s needs.

**Finding:**

Two residents with documented health changes did not have a timely review by the RN include: one resident with swollen legs, documented by a health assistant on 22 May 2014, showed no evidence of RN documented review until 27 May 2014 in the progress notes; one resident with documented  pain from the back, knees and shoulder on 7 June 2014 was given analgesia by the health assistant, with no evidence of documented follow up by the RN. There is no documented evidence of family involvement in the six monthly review of five of six files sampled (one resident has not been at the service for longer than six months).

**Corrective Action:**

Ensure that residents with health changes have a timely review by a registered nurse. Ensure that there is documented evidence that family are involved in the six monthly review of the care plan as required.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed six monthly for five of six resident files sampled. One resident has not been at the service for longer than six months. Pain assessment were not evidenced as being reviewed six monthly for five of six files sampled or with on-going monitoring recorded for two residents requiring administration of controlled medication as part of prescribed pain management plan. This is an area requiring improvement. Five family and six residents interviewed are very satisfied with the support provided.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed six monthly for five of six resident files sampled. One resident has not been at the service for longer than six months.

**Finding:**

 Pain assessments were not evidenced as being reviewed six monthly for five of six files sampled or with on-going monitoring recorded for two residents requiring administration of controlled medication as part of prescribed pain management plan.

**Corrective Action:**

Ensure pain assessments are reviewed at least six monthly for all residents and on-going pain monitoring is completed for residents with on-going pain.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The sample of files reviewed included;

One resident prescribed controlled drugs, one resident referred for another level of care, on resident recently admitted, one resident with frequent falls, one resident with a wound and one resident with challenging behaviours and weight loss.

A review of six resident files identifies the use of short term and long term care plans (link 1.3.6.1). These reflect variances in resident health status. There is evidence of six monthly reviews which is signed by a registered nurse.

The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist. However there is no documented evidence of family involvement in the six monthly review of five of six files sampled (link 1.3.3.4). One resident has not been at the service for longer than six months.

D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.

All six resident files demonstrated communication with family/EPOA.

D16.3k: Short term care plans are in use for changes in health status.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Six resident files were reviewed. Six identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurse and amended when current health changes.

Five of six care plans evidenced evaluations completed at least six monthly. One resident has not been at the service for longer than six months. Activity assessments and the activities sections in care plans have been completed by the activity coordinator. The care being provided is consistent with the needs of residents for three of six files sampled. One resident with an indwelling catheter did not have documented evidence of change of catheter, one resident with bowel difficulties did not have documented interventions in the care plan. These are areas requiring improvement.

Good care is evidenced by discussions with residents, families, health assistants, and registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of at least three monthly medical reviews (link #1.3.12.1) Residents’ care plans are completed by the registered nurse with input from the health assistants. Care delivery is recorded and evaluated by health assistants, enrolled nurse (manager) or the registered nurse in the progress notes at least daily (evidenced in all six files sampled.). When a resident's condition alters, the registered nurse initiates a review and if required arrange a GP visit or a specialist referral. The five health assistants, one registered nurse and the enrolled nurse (manager) interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, slippery sums, pressure mattresses, wheelchairs, wheel chair, sit on weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Six residents interviewed and five family interviewed were complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for four wounds including two skin lesions (one resident), one skin tear and one ulcer (one resident) and one small shin ulcer. There are no pressure areas. One resident had documented frequency of dressing as required daily on the wound management plan however this was not evidenced as completed daily. This is an area requiring improvement.

The registered nurse interviewed described the referral process and related form for referral to a wound specialist or continence nurse. 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.

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms. Residents interviewed were able to confirm that privacy and dignity was maintained.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Six resident files were reviewed. Six identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurse and amended when current health changes. Five of six care plans evidenced evaluations completed at least six monthly. One resident has not been at the service for longer than six months. Activity assessments and the activities sections in care plans have been completed by the activity coordinator. The care being provided is consistent with the needs of residents for four of six files sampled. Dressing supplies are available. Wound assessment and wound management plans are in place for four wounds including two skin lesions (one resident), one skin tear and one ulcer (one resident) and one small shin ulcer. There are no pressure areas.

**Finding:**

(i) One resident with an indwelling catheter did not have documented evidence of change of catheter. (ii) One resident with bowel difficulties did not have documented interventions in the care plan. (iii) One resident had documented frequency of dressing as required daily on the wound management plan, however this was not evidenced as completed daily. (iv) Two residents with leg oedema and one resident with a urinary tract infection did not have interventions documented in the long term care plan (LTCP) or a Short Term Care Plan (STCP) completed.

**Corrective Action:**

(I) and (ii) Ensure that interventions for residents assessed needs are documented in the care plan. (iii) Ensure that wound care is appropriate according to assessment needs.

**Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is one activities coordinator who is a qualified diversional therapist at Brooklands village rest home and is responsible for the planning and delivery of the activity programme. She has worked at the service for 18 years initially as a caregiver and as an activity coordinator for the last four years. She attends monthly meetings with other activities coordinators in the area and they share ideas. She still works as a caregiver form 6am-8am and then works in activities from 8am-1pm Monday-Friday. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and daily activities are displayed on the notice board in the lounge. Residents have their own time after lunch or attend entertainment or card games that are run by the village residents. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events. The registered nurse takes a full social history and the activities coordinator develops an activities plan with input from the resident and relative if required.

The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities. The resident/family/EPOA as appropriate is involved in the development of the activity plan if required. There is a range of activities offered that reflect the resident needs including exercises, van outings, housie and crafts. Participation in all activities is voluntary.

Brooklands village rest home has its own vans for transportation. Residents interviewed described attending concerts at schools, communion on Sundays, other rest homes visiting for quizzes, going to the Elderly Hall in Mosgiel and attending the community hall for the Taieri games with other rest homes in the area participating. The van drivers have a current first aid certificate.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is at least a three monthly review by the medical practitioner.

D16.4a Care plans are reviewed and evaluated by the registered nurse six monthly or when changes to care occur as sighted in five of six care plans sampled (one resident has not been at the service longer that six months). There are short term care plans to focus on acute and short-term issues (link 1.3.6.1). STCPs reviewed evidence evaluation and are signed and dated by the registered nurse when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. Health assistants interviewed confirmed that they are updated as to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, dietitian, speech language therapist and wound care nurse.

D16.4c: The service provided examples of where a resident’s condition had changed and the resident was reassessed for a higher level of care.

D 20.1; Discussions with the registered nurse and manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist and physiotherapist

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. 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 is made and this is documented.

Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The majority of medication policies align with accepted guidelines with some improvements required (link #1.2.3.3). Medications are stored in a locked trolley in a locked manager/registered nurse office. Controlled drugs are stored in a locked safe in the manager/registered nurse office and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. The service uses a weekly nomad system. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and/or pharmacist and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. Three out of 12 medication charts sampled had evidence of transcribing by the health assistants and registered nurse. Seven out of 12 medication charts sampled did not show evidence that inhalers or creams prescribed were signed as given. These are areas requiring improvements. The medication folder includes a list of specimen signatures.

Medication profiles are printed by the GP, are legible, up to date and six of twelve charts sampled had evidence of three monthly reviews documented on the computer by the G.P. This is an area requiring improvement. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.

Education on medication management occurred in May 2013. The registered nurse, enrolled nurse (manager) and senior health assistants administer medicines. There is no comprehensive competency assessment for staff administering medications. This is an area requiring improvement. One registered nurse and one health assistant were observed administrating medications. Both staff did not check the medication with the GP prescription and both signed for medications before they were given to the resident. This is also an area requiring improvement.

There are appropriate policies around residents who self-administer medicines. There are four residents who self-administer medicines. All have a locked drawer to store their medications however one resident on controlled drugs did not keep the drawer locked. The residents sign a form to say they take responsibility for their medications and the GP signs that they are safe to do so but there is no competency assessment of the resident or review by the service. One resident on controlled drugs was noted to have taken the wrong days medication on the day of the audit. These are areas requiring improvement. The registered nurse and manager removed all medications from residents that were self- administrating with their permission on the day of the audit and staff will now be administering medications for those residents.

D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly in six of the 12 charts sampled and this was documented in the GP progress notes on the computer.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medications are stored in a locked trolley in a locked manager/registered nurse office. Controlled drugs are stored in a locked safe in the manager/registered nurse office and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred regularly. The service uses a weekly nomad system. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and/or pharmacist and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication profiles are printed by the GP, are legible, up to date and six of twelve charts sampled had evidence of three monthly reviews documented on the computer by the G.P.

Staff sign for the administration of medications on medication signing sheet

**Finding:**

(i) Three out of 12 medication charts sampled had evidence of transcribing by the health assistants and registered nurse. (ii) Seven out of 12 medication charts sampled did not show evidence that inhalers or creams prescribed were signed as given. (iii) Six of twelve medication charts did now show evidence of three monthly reviews by the GP.

**Corrective Action:**

(i)Ensure that transcribing ceases. (ii) Ensure that inhalers and creams are administered and signed for as prescribed. (iii) Ensure that the GP reviews the resident medication three monthly and documents this on the computer.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Education on medication management occurred in May 2013. One registered nurse, one enrolled nurse (manager) and senior health assistants administer medicines.

**Finding:**

(i) There is no comprehensive competency assessments completed for staff administrating medications. A medication questionnaire is completed by staff with no further assessment of medication administration competency documented; (ii) two staff observed administrating medications staff did not check the medication with the GP prescription and both signed for medications before they were given to the resident.

**Corrective Action:**

(i) Ensure all staff who administers medications have a regular competency assessment conducted. (ii) Ensure that staff administrating medications check with the GP prescription and sign after the medication is taken.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies around residents who self-administer medicines however, these required review as per #1.2.3.3. There are four residents who self-administer medicines. All have a locked drawer to store their medications. Residents who self-medicate are given their weekly nomad pack which includes controlled drugs. Staff replace the pack each week.

**Finding:**

(i) One of the four residents who self-administer medicines did not keep her drawer locked. (ii) All four residents have not had a competency assessment completed. (iii) One resident on controlled drugs was noted to have taken the wrong days medication on the day of the audit.

**Corrective Action:**

(i) Ensure that all medications are kept in a locked drawer. (ii) & (iii) Ensure self-administration competencies are completed at least three monthly.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Brooklands village rest home has a commercial kitchen and all food is cooked on site. There is one main chef who has been qualified for 30 years and has worked at the service for 12 years. The chef also has HACCP certification and is responsible for keeping staff trained in food safety and handling. The main chef works Monday-Friday 6am-2.30pm. There is weekend cook. At the time if audit the chef was training another trainee chef as an extra back up for the service. The chef prepares the tea meal and health assistants in the evening are responsible for finishing off the preparation and serving the meal. Health assistants are responsible for dishwashing throughout the day. All staff working in the kitchen have food safety training. There is an eight weekly rotating winter and summer menu. The menu has not been reviewed by a dietitian within the last two years. This is an area requiring improvement.

A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. There are two chillers and two freezers. Food in the chiller was covered and dated. Decanted food in the pantry is not dated. This is an area requiring improvement. Food temperatures are recorded daily. Dish washer temperature is recorded daily. There are also monthly checks of electrical equipment in the kitchen and this is documented.

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review and updated annually with a new profile. Changes to residents’ dietary needs are communicated to the kitchen as reported by the registered nurse. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets being catered for include pureed diets, soft diets, vegetarian and diabetic diets. Weights are recorded weekly/monthly as directed by the registered nurses. The chef described high density foods for those with low weight with extra puddings and higher fat content. Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served directly from the Bain Marie and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a resident’s birthday choice when the resident gets to choose the meal for the day. There is home -made baking and there are always snacks available for residents. There is two weeks supply of food onsite if required in an emergency. There is a cleaning schedule which is signed by member of staff completing cleaning tasks.

D19.2 Staff have been trained in safe food handling.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Brooklands village rest home has a commercial kitchen and all food is cooked on site. There is one main chef who has been qualified for 30 years and has worked at the service for 12 years. The chef also has ASAP certification and is responsible for keeping staff trained in food safety and handling. The man chef works Monday-Friday 6am-2.30pm. There is weekend cook. At the time if audit the chef was training another trainee chef as an extra back up for the service. The chef prepares the tea meal and health assistants in the evening are responsible for finishing off the preparation and serving the meal. Health assistants are responsible for dishwashing throughout the day. All staff working in the kitchen have food safety training. There is an eight weekly rotating winter and summer menu. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. There are two chillers and two freezers. Food in the chiller was covered and dated.

**Finding:**

(i) The menu has not been reviewed by a dietitian within the last two years. (ii) Decanted food in the pantry is not dated

**Corrective Action:**

(i) Ensure that the menu is reviewed and approved by a dietitian. (ii) Ensure that decanted foods are dated.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in a cupboard on the first level away from residents and also in locked cleaning cupboards. Safe chemical handling has not been provided in the past two years (link finding 1.2.7.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Reactive and preventative maintenance occurs. There is a maintenance person who works across the rest home and retirement village. Fire equipment is checked by an external provider. The building holds a current warrant of fitness which expires 20 October 2014. Electrical equipment is checked and is next due July 2014. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. All residents wear a neck alarm that activates the call bells. All staff carry pagers and there are call bell display units through the facility. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas. Medical equipment was last calibrated in April 2014. The service has two vans and one car for transportation of residents. All vehicles have a current warrant of fitness.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, heel protectors, lifting aids, slippery sums and lazy boy chairs.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

The service has single rooms. Most rooms have a full en-suite (four rooms share an en-suite between two rooms) and there are three communal toilets and two communal showers for eight residents which are close to the bedrooms. Toilets are located close to dining rooms and lounges for residents' use. A visitor’s toilet is available. Water temperatures are tested monthly by the maintenance person and records show they are within safe limits. Residents and health assistants interviewed report there are sufficient toilets and showers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Observation on day of audit demonstrated walking frames and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with health assistants. Residents were observed manoeuvring walking frames in rooms safely. Residents interviewed are very happy with their rooms.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is one main lounge and dining area and two smaller lounges. There is also a sun gallery seating area that has a musical organ of which one of the residents frequently plays. The lounges and dining room are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All laundry is completed on site. There is one staff member who works in the laundry 10.30am-3pm. She has worked at the service for 11 years. There are two cleaners on daily. Chemicals were evidenced stored securely in a cupboard on the first level away from residents and also in locked cleaning cupboards. All chemicals are labelled with manufacturer’s labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Housekeeping audit was last conducted in April 2014 and laundry audit conducted in February 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has policies and procedures and training for civil defence, other emergencies and security. Emergencies policies include medical, fire, earthquake, security, civil defence, death and dying, falls, life support and use of restraints. The fire and emergency manual is kept in the nurse’s office and is available on the computer. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 4 May 1989. Fire evacuation drills have occurred six monthly - last conducted on 11 March 2014. Battery operated emergency lighting, extra torches and gas cooking and is available. The service is able to obtain a generator from within the community if required in an emergency. Call bells are evident in resident’s rooms, en-suites, corridors, lounges and dining rooms and toilets/bathrooms. Security policies and procedures are in place. Care staff conduct checks on all external doors through the facility at night fall. There are civil defence supplies available including torches, food and water. A first aid kit is available and checked and maintained monthly.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility has heat pumps in hallways and communal areas for heating. All resident’s rooms have a column heater. The temperature can be adjusted to suit individual resident temperature preference. Rooms are well ventilated and windows provide natural light. Facility temperatures are monitored. Six residents interviewed stated the temperature of the facility was comfortable.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Brooklands village rest home has comprehensive policies and procedures on restraint minimisation and safe practice. The registered nurse is the restraint coordinator and confirms that the service promotes a restraint-free environment.
Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.
Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms which are available if required. Restraint education last provided for staff in 2014 which was associated with policy review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Brooklands village rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by the registered nurse and manager. The registered nurse is the infection control coordinator. The quality assurance team incorporates the infection control committee. Discussion and reporting of infection control matters and consequent review of the programme is conducted at the staff/quality meetings. Annual review was conducted in December 2013. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (June 2014). Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The registered nurse is the infection control officer and is experienced in the role. The RN is supported by the manager and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The registered nurse attended an infection control (IC) training course provided by the local district health board in 2013. The IC officer and staff have good external support from the local laboratory infection control team and IC nurse expert at Southern DHB. The infection control team is representative of the facility.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are infection control policy and procedures appropriate to for the size and complexity of the service.
D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the manager and registered nurse. The policies and procedures were last updated and reviewed in December 2013. Brooklands village rest home’s infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control coordinator. All infection control training is recorded, with improvements required around documenting session content and records of attendance (link #1.2.7.5). Infection control education was provided in June 2014 by the infection control expert from the local DHB. It is also included in the annual staff training session. The infection control officer attended infection control training in 2014. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been recorded in the past two years. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Brooklands village rest home’s infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. Resident infections are collated on a monthly reporting form which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored, graphed and evaluated monthly and annually. Outcomes and actions are discussed at the quality assurance meetings. If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past two years.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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