# Bosnyak Lifecare Management Limited

## Current Status: 7 July 2014

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

## General overview

Regency Home and Hospital provides rest home and hospital level of care for up to 92 residents. This includes an 18 bed specialist secure dementia unit. At the time of audit there are 83 residents (38 rest home, 28 hospital and 17 in the secure unit), two of these being younger people with disabilities. The residents and families interviewed report that the quality of the staff is one of the strengths of the service.

There is one area requiring improvement identified at this audit, related to the orientation process for temporary staff. There is one area that has received a continuous improvement rating (rated beyond the full attainment) for the review, analysis and evaluation of the quality improvement systems.

## Audit Summary as at 7 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 7 July 2014

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

### Organisational Management as at 7 July 2014

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

### Continuum of Service Delivery as at 7 July 2014

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

### Safe and Appropriate Environment as at 7 July 2014

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

### Restraint Minimisation and Safe Practice as at 7 July 2014

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

### Infection Prevention and Control as at 7 July 2014

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

## Audit Results as at 7 July 2014

### Consumer Rights

The service has processes in place that demonstrates their commitment to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ right is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents in the rest home, hospital and specialist secure dementia sections are provided with care and services that maximises each resident’s independence and reflects the residents’ and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural choices, values and beliefs are practiced at the service.

Residents receive services of an appropriate standard for the hospital, rest home and specialist dementia level of care. The service provides an environment that encourages good practice.

Staff communicate effectively with residents and provide an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff is demonstrated. The service demonstrates that written consent is obtained and any advance directives are actioned appropriately by staff. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

### Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified. The service is managed by an appropriately experienced and qualified manager who is responsible for the overall day to day operations of the service. The manager is supported by a clinical leader and a clinical team.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The service has conducted a number of quality improvements, which exceed the full attainment rating and have gained a continuous improvement rating for the ongoing implementation of the quality improvements at the service.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There are established processes for the orientation of new staff members. When temporary/bureau nurses are utilised to cover shifts, these staff have a clinical handover regarding the residents and the residents care needs, though there is no documented process for the orientation of these temporary staff to other essential components of service delivery. This is an area identified that requires improvement.

There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of hospital, rest home and specialist dementia levels of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for all staff and education records are well maintained. The staff who work in the secure dementia unit have the required specialist national qualifications in the provision of dementia care.

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

### Continuum of Service Delivery

There were clearly documented processes for entry to the facility. Admissions were managed in an equitable and timely manner. Care and support was provided by a range of health professionals and clear time frames for service provision were defined and maintained. Assessments and care plans were fully documented and interventions were consistent with good practice and desired outcomes. Care plans were reviewed and updated as required.

Residents maintained access to a range of health services. Referrals and transfers were managed in the timely and appropriate manner. Records of referrals and transfers were maintained and there was evidence that family were involved.

Individual activities were planned to meet the needs of the resident. The weekly activities plan was displayed. Activity goals were detailed and ensure the provision of relevant and appropriate activities for each resident. Previous interests, hobbies and ability were considered. Sufficient activities and outings were provided.

There was an appropriate medication management system. All medications were stored securely. Medications were monitored and administration was conducted by staff who were assessed as competent to do so.

Food and nutritional needs of residents were assessed and the menu was appropriate to the nutritional needs of residents. Special needs were catered for and monitored. Food preparation and storage met food safety requirements.

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### Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and secure dementia level of care. The service ensures physical privacy is maintained, has adequate space and amenities to facilitate independence and is in a setting appropriate to the needs of both younger and older people at the service. Residents, visitors, and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

Residents are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. The facilities for the residents living in the dementia unit provide a safe and secure environment for residents to wander freely. All buildings, plant, and equipment comply with legislation. There is an ongoing refurbishment and maintenance schedule. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.

The facility has an appropriate call system for residents to request assistance from staff. The building has a current building warrant of fitness. Residents have access to gardens and courtyards. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Residents are provided with adequate toilet/shower/bathing facilities. All rooms in the rest home and hospital have either single or shared ensuite facilities. The rooms in the dementia unit have ensuite toilets. There are additional common facilities conveniently located throughout the service. Residents are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

### Restraint Minimisation and Safe Practice

There were adequately documented guidelines on the use of restraints and enablers and behaviours of concern. Restraint use was minimised if able and the use of enablers was voluntary. In the event of restraint use, the required approval, consent, assessment, monitoring and review was conducted. The safety and use of restraint was reviewed regularly to ensure ongoing appropriateness.

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### Infection Prevention and Control

The infection control programme was clearly documented and was suitable for the facility and services provided. Infection control responsibilities were clearly documented. Adequate information, resources and on-going training were provided. External expert advice was sought if required. Infection control was included in health and safety, quality and risk management, and emergency systems.

The infection surveillance program was appropriate for the facility. The use of antibiotics was monitored and infection rates were benchmarked for quality improvement purposes. In the event of an outbreak the organisation had the required resources and expertise to minimise the impact and spread.

# 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:** | Bosnyak Lifecare Management Limited |
| **Certificate name:** | Bosnyak Lifecare Management Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Regency Home and Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 7 July 2014 | **End date:** | 8 July 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 83 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 16 | **Hours off site** | 12 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 14 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 30 | Total audit hours off site | 21 | Total audit hours | 51 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed |  | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 10 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 20 | Total number of staff (headcount) | 43 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Monday, 14 July 2014

## **Executive Summary of Audit**

**General Overview**

Regency Home and Hospital provides rest home and hospital level of care for up to 92 residents. This includes an 18 bed specialist secure dementia unit. At the time of audit there are 83 residents (38 rest home, 28 hospital and 17 in the secure dementia unit), two of these being younger people with disabilities. The residents and families interviewed report that the quality of the staff is one of the strengths of the service.

There is one area requiring improvement identified at this audit, related to the orientation process for temporary staff. There is one area that has received a continuous improvement rating (rated beyond the full attainment) for the review, analysis and evaluation of the quality improvement systems.

**Outcome 1.1: Consumer Rights**

The service has processes in place that demonstrates their commitment to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ right is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents in the rest home, hospital and specialist secure dementia sections are provided with care and services that maximises each resident’s independence and reflects the residents’ and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural choices, values and beliefs are practiced at the service.

Residents receive services of an appropriate standard for the hospital, rest home and specialist dementia level of care. The service provides an environment that encourages good practice.

Staff communicate effectively with residents and provide an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff is demonstrated. The service demonstrates that written consent is obtained and any advance directives are actioned appropriately by staff. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

**Outcome 1.2: Organisational Management**

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified. The service is managed by an appropriately experienced and qualified manager who is responsible for the overall day to day operations of the service. The manager is supported by a clinical leader and a clinical team.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The service has conducted a number of quality improvement, which exceed the full attainment rating and have gained a continuous improvement rating for the ongoing implementation of the quality improvements at the service.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There are established processes for the orientation of new staff members. When temporary/bureau nurses are utilised to cover shifts, these staff have a clinical handover regarding the residents and the residents care needs, though there is no documented process for the orientation of these temporary staff to other essential components of service delivery. This is an area identified that requires improvement.

There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of hospital, rest home and specialist dementia levels of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for all staff and education records are well maintained. The staff who work in the secure dementia unit have the required specialist national qualifications in the provision of dementia care.

Resident information is uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and is not accessible or observable to the public.

**Outcome 1.3: Continuum of Service Delivery**

There were clearly documented processes for entry to the facility. Admissions were managed in an equitable and timely manner. Care and support was provided by a range of health professionals and clear time frames for service provision were defined and maintained. Assessments and care plans were fully documented and interventions were consistent with good practice and desired outcomes. Care plans were reviewed and updated as required.   
  
Residents maintained access to a range of health services. Referrals and transfers were managed in the timely and appropriate manner. Records of referrals and transfers were maintained and there was evidence that family were involved.   
  
Individual activities were planned to meet the needs of the resident. The weekly activities plan was displayed. Activity goals were detailed and ensure the provision of relevant and appropriate activities for each resident. Previous interests, hobbies and ability was considered. Sufficient activities and outings were provided.  
  
There was an appropriate medication management system. All medications were stored securely. Medications were monitored and administration was conducted by staff who were assessed as competent to do so.  
  
Food and nutritional needs of residents were assessed and the menu was appropriate to the nutritional needs of residents. Special needs were catered for and monitored. Food preparation and storage met food safety requirements.

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Food and nutritional needs of residents were assessed and the menu was appropriate to the nutritional needs of residents. Special needs were catered for and monitored. Food preparation and storage met food safety requirements.

**Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and secure dementia level of care. The service ensures physical privacy is maintained, has adequate space and amenities to facilitate independence and is in a setting appropriate to the needs of both younger and older people at the service. Residents, visitors, and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

Residents are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. The facilities for the residents living in the dementia unit provide a safe and secure environment for residents to wander freely. All buildings, plant, and equipment comply with legislation. There is an ongoing refurbishment and maintenance schedule. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.

The facility has an appropriate call system for residents to request assistance from staff. The building has a current building warrant of fitness. Residents have access to gardens and courtyards. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Residents are provided with adequate toilet/shower/bathing facilities. All rooms in the rest home and hospital have either single or shared ensuite facilities. The rooms in the dementia unit have ensuite toilets. There are additional common facilities conveniently located throughout the service. Residents are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

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

There were adequately documented guidelines on the use of restraints and enablers and behaviours of concern. Restraint use was minimised if able and the use of enablers was voluntary. In the event of restraint use, the required approval, consent, assessment, monitoring and review was conducted. The safety and use of restraint was reviewed regularly to ensure ongoing appropriateness.

There were adequately documented guidelines on the use of restraints and enablers and behaviours of concern. Restraint use was minimised if able and the use of enablers was voluntary. In the event of restraint use, the required approval, consent, assessment, monitoring and review was conducted. The safety and use of restraint was reviewed regularly to ensure ongoing appropriateness.

**Outcome 3: Infection Prevention and Control**

The infection control programme was clearly documented and was suitable for the facility and services provided. Infection control responsibilities were clearly documented. Adequate information, resources and on-going training were provided. External expert advice was sought if required. Infection control was included in health and safety, quality and risk management, and emergency systems.   
The infection surveillance program was appropriate for the facility. The use of antibiotics was monitored and infection rates were benchmarked for quality improvement purposes. In the event of an outbreak the organisation had the required resources and expertise to minimise the impact and spread.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 99 | 0 | 1 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | There is no documented process for the orientation of agency/bureau nursing staff that covers the essential components of service delivery. | Ensure the agency/bureau staff receive an orientation/induction programme that covers the essential components of the service provided. | 180 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The achievement of the quality improvements and quality management systems is rated beyond the expected full attainment. The quality improvement systems sighted have a documented monthly and annual review process which includes analysis and reporting of findings to management, the director, staff and residents. The annual review of the quality data and achievements against the quality plan clearly document evidence of actions taken based on findings and improvement to service provision. Resident safety and/or satisfaction have been measured as a result of the review process. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. The staff knock on doors before entering resident bedrooms, use residents’ preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (15 staff from across all areas, including nursing, caregivers, activities, domestic services and kitchen service) confirm they respect the resident’s right to refuse cares or interventions. Staff can verbalise ways they deal with situations that arise which ensure residents’ rights are maintained. This is confirmed during interviews with nine of nine residents (six rest home and three hospital) and six of six family/whānau members (includes families of residents living in the dementia unit).

The Age Related Residential Aged Care (ARC) requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

Opportunities are provided for explanations, discussion, and clarification about the Code of Health and Disability Services Consumers’’ Rights (the Code) with the resident, family/whānau as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service is clearly displayed at the entrance to the facility and available to residents and visitors. Staff education on the Code and Advocacy services is last conducted in May 2013. Interviews with nine of nine residents and six of six family/whānau report they are informed of their rights and that staff always respect all aspects of their rights. The 10 of 10 resident files reviewed contain a copy of the Code, and that the resident (or where applicable the EPOA) have signed that they have read and understood their rights and responsibilities.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The environment allows residents physical, visual, auditory and personal privacy. All rooms are single occupancy. Discussions with three registered nurses (RN)s and six family/whānau members confirms that there are many areas available for residents and family/whānau to talk in private.

Resident’s needs, values and beliefs, including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in the 10 of 10 resident file reviews (four rest home, three hospital and three dementia) which identify interventions put in place to meet the identified needs.

As observed at the time of audit services are provided in a manner that maximises each resident’s independence and allows choices to be respected. Residents and family/whānau report that they are treated with respect and that residents receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. This finding is confirmed during nine care staff interviews (three RNs and six caregivers) and the sighted responses from the resident satisfaction survey results.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Maori health plan sighted records that it is developed in consultation with a Maori cultural advisor. The goal of the policy is to provide at least the same level of health for Maori as non-Maori, safeguarding Maori cultural concepts, values and practices, using a holistic approach to care incorporating the four cornerstones integral to Maori health: Whanau (family), Tinana (physical), Hinengaro (mental) and Wairua (spiritual). Family/whanau participation in resident care (where the resident has a desire for this support) is actively encouraged and supported by the Organisation.

The manager reports that there are no known barriers to Maori accessing the service. At the time of audit there are no residents who identify as Maori. The manager reports that there is one Maori resident who comes in for regular respite, and reports that they and their whanau are happy’ with the services provided at Regency. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with nine care staff (three registered nurses (RNs) and six caregivers). Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. Cultural education, which includes Maori beliefs, is last conducted in February 2013.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The cultural safety policy sighted providers further details of providing care for the older person who identifies as Maori. The policy also records that an accurate assessment of resident’s cultural needs will be completed as part of the admission process. Staff will be guided by the wishes of the resident, their family and whanau regarding cultural needs and culturally appropriate practices.

Interviews with nine of nine residents and six of six family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care plan (as sighted in 10 of 10 resident file reviews). An interview with a resident with a cultural background from the Philippines reports they receive excellent care at Regency.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

The eight of eight staff record reviews, (the manager, nurse leader (RN), one other RN, two caregivers, one activities coordinator, one laundry/domestic worker and one cook) identify that staff sign a code of conduct that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory.

Interviews with 15 of 15 staff (three RNs, six caregivers, two activities coordinator, three domestic staff and one cook), nine residents, one GP, and six family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation at Regency.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Interviews with nine care staff (three RNs and six caregivers) confirm that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. The GP visits regularly and the service has established links with other local health services, the DHB and hospice for ongoing education and support. The gerontology nurse specialist visits residents as required and to deliver specialist education to staff.

There is regular in-service education and staff access external education that is focused on aged care such as care planning, specific medical conditions, wound management, palliative care and dementia care. All educational material sighted is evidenced to current best practice or evidenced based practice. There is a ‘weekly focus’ meeting in which specific areas of resident care or concerns are discussed and communicated with the care staff. The manager, RNs and caregivers interviewed report that the weekly focus meeting is increasing awareness of specific aspects of care and is having a ‘positive impact on increasing the quality of care’ to residents.

Interviews with nine of nine residents and six of six family/whānau members confirm their high level of satisfaction with all care delivery and staff attitude. Two of the residents report that they have lived in other care facilities in the past are ‘really happy with the atmosphere and caringness’ of all the staff. This is further supported by the results of the 2013 resident satisfaction survey, where there is a recorded 100% satisfaction with the overall care and services provided at Regency.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policy related to open disclosure is implemented by the service. Interviews with six of six family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. The resident, and family/whānau, are invited to resident reviews and they have documented input into setting annual goals and evaluating services that are in place. The residents and family interviewed report that management are ‘very approachable’ and they feel they can speak to the manager and nurses any time about the care of their relative. Family communication is clearly documented in the 10 of 10 resident file reviews and on incident and accident forms sighted.

Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. At the time of audit there are two residents who have limited communication in English, though these residents are able to effectively communicate with staff. There are a number of staff who are bilingual and can interpret as required.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

General consents include activities and outings, identification, sharing of health information, personal care and nursing, primary medical care, resident rights and responsibilities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The 10 of 10 resident file reviews and interviews with five of five residents and six of six family/whānau members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau is encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family/whānau members confirm their awareness of where to locate the information.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Interviews with nine of nine residents confirm they have access to visitors of their choice. The six family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.

Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in 10 of 10 residents’ files identify that regular community outings occur, the frequency which residents go out with friends and family and the community services who visit the facility. For example weekly RSA visits, regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended services in the community. On the days of audit it is observed that resident went out to partake in community and family activities.

The ARC requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has an up-to-date complaints register which identifies the date of the complaint, the complainant, description of the issue and the actions taken. The register contains a summary of written and verbal complaints. There are no outstanding complaints regarding the service at the time of audit. There is one complaint that has been received through the Health and Disability Commissioner in 2013, which is resolved and required no further action. Two other complaints sampled for 2013 and to date in 2014, indicate the complaint was investigated within the time frames of Right 10 of the code.

Complaints data is a standing agenda item for all staff meetings. Follow up actions are monitored by senior staff and discussed in the quality meeting. The nine residents and six family/whanau interviews confirm they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. The information given to all residents and family/whanau upon admission includes complaints forms and a full explanation of how the system works. This information on making a complaint or providing feedback is in the residents welcome booklet. Advocacy information is also included in the admission booklet. Both complaints and advocacy information is on full display at the entrances to the facility.

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

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The sighted mission is to promote the dignity and self-worth of all of our residents, and strive to give them excellent quality of life, individually and as a group. There is weekly and monthly monitoring and reporting of goals and objectives. There is a monthly governance meeting and a weekly report is sent to the director (Mondays). The monthly governance meeting minutes are sighted for 2014. The monthly governance meeting includes a summary of complaints and complements, policy reviews, training, resident issues, incidents/accidents, infection control, staffing, health and safety, food services, activities, cleaning, laundry and review of the quality plan.

The service is managed by the manager who is an enrolled nurse (EN), annual practising certificate (APC) sighted. They have been in the current position since November 2012, and have worked at the service in past for a total of 20 years (as an EN and manager). The job description identifies clear lines of authority, accountability and responsibility for the provision of services. The manager attends on-going education relevant to their role which includes regular attendance at in-service education. Ongoing education includes attendance at aged residential area managers workshop and forum (April 2014) and other education related to the clinical aspects of care and diseases related to the older person. The manager receives updates from an aged care association on current legislation, issues and practice related to the management of aged care services.

The manager is support by a clinical leader (RN). The 15 of 15 staff and GP report the service is managed very well.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During a temporary absence a suitably qualified and/or experienced person performs the manager's role. The clinical leader fills in the manager’s role. The clinical leader is a registered nurse (current APC sighted) and has worked at the service for over nine years. The clinical leader attends ongoing education in aged care. The manager reports confidence in the clinical leader’s ability to perform the manager’s role during temporary absences. The clinical leader reports they feel confident to perform the role of manager during temporary absence.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The sighted quality risk and management policy outlines the quality and risk management process. There are set goals and how these are to be measured. The goals for 2014 include building on the progress made in the previous year in providing and responding in a timely manner to resident needs. There are goal set for staff training, infection prevention and control, staff to be actively involved in the quality programme, care planning, health and safety and quality improvements.

The responsibility for risk management is delegated to the manager by the owners. The risk management policy includes risk categories of resident care, clinical staff, employee, property, financial, corporate governance, and other risks. The plan describes the risk, who is responsible and frequency of monitoring. The service has a quality committee which meets monthly to review all quality data. The quality data for falls, bruising, wounds, infections, and challenging behaviours is benchmarked with another aged care service. The quality facilitator produces a monthly report which includes infection control, health and safety, hazards, restraint, complaints, staffing changes, care planning, environmental matters, equipment, maintenance, education and quality improvements. This data is also reviewed and evaluated annually for any additional trends and areas to focus on for improvements in the next year (also refer to 1.2.3.6). All information is tabled at the staff meeting and displayed in the staff office areas.

All data is trended and trends are analysed by the quality committee and corrective action plans are developed as required. Results of trends and required corrective actions are discussed at the monthly staff meetings as confirmed by staff and management interviews and in minutes sighted. Data is benchmarked by an external contracted service and all results are shared with all staff. Interviews with six of six caregivers and three RNs confirm they are aware of quality systems and that they are informed of audit results at staff meetings. Staff confirm that open discussion occurs related to all quality and risk issues and that meetings are used to measure quality improvement outcomes (sighted in meeting minutes). See 1.2.3.6 for the continuous improvement rating for the analysis and review of the quality systems and quality data.

There is a document control system to manage the policies and procedures. The polices are updated at least two yearly, or earlier if there are legislative changes. The policies and procedures are reviewed by a quality facilitator. New and updated policies are displayed in a folder and staff sign that they have read the updated policies. The staff only have access to current policies and procedures, with obsolete documents removed from staff access.

Management operate an open door system as confirmed during resident and family/whanau interviews. Any issues or concerns are dealt with promptly. Family/whanau interviews and documentation sighted in 10 of 10 resident files confirms they are notified appropriately if any changes are made to their relatives care provision, of any medication changes and if staff have any concerns including immediate notification of any incidents or accidents.

The service has an internal auditing system, with audits delegated to committee members to complete and return. The service has a quality committee which meets monthly to look at all quality data. They produce a monthly report which includes infection control, health and safety, hazards, restraint, complaints, staffing changes, care planning, environmental matters, equipment, maintenance, education. Board of Trustee meeting outcomes and quality improvements. All information is taken to the full staff meeting as identified in minutes sighted.

The weekly focus meeting, internal audits, quality and risk data evaluation and consumer surveys are used to indicate achievement measurements. Documentation identifies that corrective actions are put in place as required and evaluated to see if they have improved the service. Corrective actions are put into place to address identified areas for improvement as appropriate. Corrective action plans sighted cover all aspects of service delivery and they are discussed at all levels of the organisation. Corrective actions are developed as a result of identified trends from monthly data collation, internal and external audit results, deficits identified by staff during meetings, as a direct result of resident survey results and from complaints received. Corrective action plans sighted have measurable outcomes and they are evaluated in a timely manner. Corrective actions are clearly written and easy to follow.

The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes. Interviews with six of six caregivers confirms their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards is set out in the information book given to all residents and family/whanau members.

Monthly staff and management/governance meetings have trended data and benchmarking results presented as part of the standing agenda. Meetings are used to review corrective actions put in place. This is confirmed by minutes sighted which identify that meeting topics include matters arising, equipment, care planning, governance meeting outcomes, maintenance, complaints, staffing, wound care, resident transfers, restraint, education, environmental issues, health and safety, complaints, accident and incident reporting, infection control, and quality improvements

The nine resident and six family/whanau interviews confirm any issues that are raised are addressed promptly and that they are kept informed of the outcome. Satisfaction survey results confirm interview findings. Family and resident feedback is sought through satisfaction surveys (conducted annually in July, sighted for July 2013). These surveys sighted have a very satisfied, satisfied or not applicable feedback for aspects of the surveys. The satisfaction survey records an overall 100% satisfaction from respondents about their satisfaction with the overall care and services provided at Regency. The manager reports that any negative feedback has been followed up accordingly.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** CI

**Evidence:**

The annual review of the services and performance in 2013 (conducted January 2014) evaluates the services performance in service delivery, resident and family satisfaction, risk management and health and safety. The annual review evaluates the collected and analysed data for the previous 12 months. The review also includes the preface against previous year’s results (going back to 2009). The annual review documents improved results in the coordination and delivery of care with the introduction of weekly clinical meetings. It is documented that the weekly focus is successful in communicating to staff any areas of concern. The review records that the implementation of the weekly focus meetings has improved continuity of care and is reducing “mistakes’ and “staff stating they were unaware of specific resident needs” is able to be identified and addressed. The annual review also records that there are improvements in the wound and skin tear monitoring and healing timeframes. The resident satisfaction is measured through resident forums, review of feedback from resident meetings and the resident satisfaction survey. The resident survey records that 100% of the respondents are satisfied with the services provided at Regency.

**Finding:**

The achievement of the quality improvements and quality management systems is rated beyond the expected full attainment. The quality improvement systems sighted have a documented monthly and annual review process which includes analysis and reporting of findings to management, the director, staff and residents. The annual review of the quality data and achievements against the quality plan clearly document evidence of actions taken based on findings and improvement to service provision. Resident safety and/or satisfaction have been measured as a result of the review process.

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An alert system will be in place that identifies all adverse, unplanned or untoward events and provides an opportunity for improvement to manage risk. The staff and management interviewed understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The manager reports that there have been no serious incidents or accidents that have required essential notification. There was an outbreak that was notified to the DHB in December 2013/January 2014 (refer to 3.2 and 3.5). Interviews with the staff confirm their understanding of the need to document all adverse events.

The service uses accident and incident forms to document adverse, unplanned or untoward events. This information is monitored, evaluated and benchmarked. The monthly reports of the incidents and accidents records the number of incidents and accidents. The data is benchmarked with another care aged care facility. The data includes the total number of falls, times of falls, if any trends have been identified and the identification of frequent fallers. Shortfalls identify opportunities to improve service delivery and manage risk, this includes implementing strategies at the increased times of falls, or specific interventions for frequent fallers. Results of incident and accident trend analysis are discussed at the monthly staff and management meetings and reports are presented to the owners as appropriate (eg, if there is serious injury).

The nine of nine residents, six of six family/whanau member interviews, and documentation sighted on incident/accident forms in 10 of 10 residents’ files, confirms family/whanau are kept well informed of their relatives care requirements and are contacted appropriately by the service if there are any concerns.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The manager ensures that staff who require practising certificates have them validated annually. Practising certificates are sighted for all staff and contracted staff who require them (this includes RNs, ENs, GPs, physiotherapist, podiatrist, dietitian and medical imaging technologists).

Human resources practices are implemented as per policy requirements and seven of seven staff record reviews identify that staff are employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate. Staff appraisals are up-to-date and used as a method for staff to identify educational needs. The sighted annual performance appraisal or three month post-employment reviews are based on the staff members role and job description.

It is noted that in one of the resident files reviewed, there was an incident where a bureau RN did not know where to find some of the equipment required for the medicine management of a resident. There is a clinical handover report for agency/bureau staff, though there is no specific orientation for agency/bureau staff to the physical environment/location of equipment. This is an area for improvement at 1.2.7.4.

The service undertakes regular in-service staff education which is well documented and identifies that guest speakers/educators along with current RNs present education (content of education sighted). The service accesses ongoing education through the DHB’s aged residential care education programme and education through the local hospice. Staff confirm during interview that they have access to external education/training and this is highlighted in seven of seven staff files reviewed. Each staff member has a clearly identified education attendance record. Education sighted covers all key components of service delivery.

All staff working in the dementia unit have completed the required dementia specific unit standards. The service supports the care staff to complete their national qualification in the support of the older person.

The nine of nine residents and six of six family/whanau interviews and the July 2013 resident survey results sighted confirms services are delivered in a manner to meet required needs. The residents and families report that the quality of the care and caring nature of the staff is one of the strengths of the service.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**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:** PA Low

**Evidence:**

The orientation programme is sighted for all of the eight of eight staff files reviewed. The nine of nine care staff (three RNs and six caregivers) interviewed report a good orientation process that covers all aspects of care and service provision. There is no documented process for orientation of temporary/agency/bureau staff. There is extra time allocated at the start of a shift when an agency/bureau staff are working, though there is no documented process for orientation to the environment. The manager reports that where possible shifts are covered with their own staff, but on occasions agency/bureau staff are required. Over the past four weeks there has been one shift that has required to be filled by a bureau RN.

**Finding:**

There is no documented process for the orientation of agency/bureau nursing staff that covers the essential components of service delivery.

**Corrective Action:**

Ensure the agency/bureau staff receive an orientation/induction programme that covers the essential components of the service provided.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The sighted staff management policy clearly documents the process which determines service provider levels and skill mixes in order to provide safe service delivery. The policy describes the staff ratio based on bed occupancy. The policy documents that the duty leader has the authority to extend hours of care staff as required to meet the needs of the residents. The service delivery policy references the Indicators for Safe Aged Care and Dementia care staffing guidelines.

Stage two: The manager (EN) and clinical leader (RN) work Monday to Friday. They are not counted as numbers on the roster for determining staff to patient ratios. The staffing ratios are developed for each of the rest home, hospital and secure units. The rosters sighted for the care staff confirm the following:

-rest home (maximum of 44 residents): morning duties there is one RN (Monday to Saturday with a senior caregiver on Sundays) and three caregivers (staggered finishing times), afternoon shift one RN and 2 caregivers (staggered finishing ties).

- hospital (maximum of 30 residents): morning shift there is one RN and five caregivers (staggered finish times) and afternoon shift there is one RN and three caregivers.

- secure dementia unit (maximum of 18 residents): there is one RN (shared with the rest home) and two caregivers and afternoon shift there is one RN (shared with the rest home) and two caregivers with staggered finish times).

For night shift for the whole service, there is one RN and three caregivers. There is at least one RN on duty at all times and at least one care staff member in the secure dementia unit at all times. When there is one staff member on duty in the secure dementia unit, they are able to call for assistance from the staff in the other areas of the service if this is required.

Though the staffing is allocated for each level of care, the caregivers report there is good team work and when available they assist in other areas of the service if required (eg rest home caregiver assists in the hospital when they have completed their rest home work). There are adequate numbers of support staff, that include administration, cook, kitchen assistants, cleaning staff, laundry staff and two activities coordinators. One of the activities coordinators has the required dementia specific unit standards qualification.

Interviews with six caregivers (from rest home, hospital and secure unit and staff who have worked morning, afternoon and night shifts) confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. This is supported by interviews undertaken with nine of nine residents and six of six family/whanau members.

The ARC requirements for hospital level of care are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The 10 resident file reviews identify that information is managed in an accurate and timely manner. Health information is kept in secure areas in the nurses’ station and is not accessible or observable to the public. Archived records are securely stored onsite. The entries in the progress notes clearly identify the name and designation of the staff member. Staff members have a printed stamp that can be used to record their name and designation. The 10 of 10 residents’ files reviewed demonstrate the records pertaining to individual residents are integrated.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are documented processes for the management of enquiries and entry. These include eligibility and prioritising referrals. The manager maintains a record of all enquiries and provides the local needs assessor with current bed availability. Information for potential residents is available on the elder net web site and an initial contact information sheet is completed which confirms that potential residents are given information regarding fees and financial assistance is given. Interested parties are also given the welcome booklet and the manager reports a follow up phone calls is made

Decisions on acceptance to entry are determined on level of need and bed availability. The manager interviewed reports that there is currently no one on the waiting list. Eighty-three out of 92 rooms are currently full. There are two vacancies in the hospital, two in the secure dementia unit and five in the rest home.

A post admission checklist is maintained to ensure all admission requirements are conducted within the specified time frames (sighted). All residents sign an admission agreement on entry and these are sighted within the sample. The agreement clearly identifies the services provided (and not provided) as part of the agreement. Additional charges (where applicable) are identified. Signed agreements for residents in the dementia unit are signed by those who have the authority to do so.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The manager reports that declines are made if the potential resident is not considered suitable or there is no bed availability. It is reported that in this event the manager provides a list of local rest homes or alternative providers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures require each stage of service provision to be completed by a suitably qualified person. This includes the requirement for a registered nurse to complete all assessments, care plans and care plan reviews. Ten resident files are sampled. This includes three residents receiving hospital level, three residents receiving secure dementia care and four residents receiving rest home level care. Confirmation of the registered nurse completing the required assessments is confirmed in the sample.  
  
Interventions and support with activities of daily living are implemented with the help of trained health care givers and allied health providers. Care givers interviewed are well versed in their required tasks and keep records of all daily interventions.   
  
Timeframes for service delivery are defined. This includes the time frame for completing assessments on admission and long term care plans within three weeks of entry. All records sighted have had the long term care plan completed within the required timeframe. The residents’ care plans are reviewed every six months and again annually and this is fully documented. Medical reviews are completed by the general practitioner (GP) every month or three monthly (depending on the residents’ level of need). Short term care plans are developed in the event additional cares are required, and these are consistently sighted within the sample.  
  
Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity. A handover is observed and confirms that adequate and appropriate information is shared between nurses and staff. Registered nurses also attend regular meetings which include a large clinical component and ensure all nurses are kept aware of the residents’ current condition. Clinical reports are also communicated to the board every month. These include the number of wounds, infections, falls and use of restraints. Records of GP rounds are maintained by the clinical leader for handover to the registered nurses. Shift handover reports are sighted.  
  
The District Health Board requirements are met.

Tracer one:

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

Tracer two:

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

Tracer three:

*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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Admission assessments includes baseline recordings, physical assessment, pressure area risk, level of support required to complete activities of daily living, cognitive status, behaviour, falls risk, bed rail usage assessment tool, sensory needs, nutritional status, continence, personal cares, pain, skin care, medications and any additional assessments as required. For example additional assessments sighted include malnutrition universal assessment tool, mini mental status assessment, physiotherapy assessments, balance testing, occupational therapy assessments and activities coordinator assessments.

Appropriate assessments are sighted in 10 out of 10 resident records sampled. Where required assessments are updated as required. Needs assessments are also sighted and confirm the appropriate level of care and placement.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Domains for life style care plans include medical issues, special alerts, medications, clinical management, safety issues, equipment needs, transferring and mobility, wandering, pressure care, hearing, communication, behaviour, nutritional needs, elimination, cultural and social, sexuality, spirituality, personal hygiene, clothing management and rest period and settling. Goals and related interventions (including routine observations) are documented for each domain.

Short term care plans are well utilised for any additional support needs. If the short term need becomes a long term concern, it is added to the long term care plan. Staff interviewed report they have full access to care plans and are encouraged to read them.

Additional care plans are documented in the secure dementia area. These include the required interventions over a 24 hour period. The 24 hour support plans sampled are comprehensive and include the resident’s idiosyncrasies, likes, dislikes and methods for managing any behaviours of concern. If required a behaviour management plan is documented.

All care plans sampled provide evidence of service integration. Physiotherapy plans, occupational therapy plans, nutritional plans and activities plans are also documented and sighted in the sample.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Interventions are documented for each nursing objective/goal within the care plan and there is evidence in progress notes that the required interventions are being provided. The GP interviewed is confident that prescribed interventions are implemented and any deviations are reported in a timely manner.   
  
The provider uses a number of short term care plans when required. Short term plans and interventions sighted within the sample include pain, impaired skin integrity, wounds, infections, weight monitoring and behaviour. Wound care plans include the required assessment and monitoring interventions, as does the care plan for a resident with an infection. In addition, regular interventions such as nursing observations and care giver tasks are documented. These include bowel charts, temperature/pulse and blood pressure charts and activities of daily living charts. There is a system in place to ensure these interventions are monitored by the registered nurses and this is confirmed in records sampled and interview with the nurses.  
  
The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are two designated activities staff on site five days per week. Both are interviewed and report they are also available to come in for any special events/occasions. Both are training for the national certificate in occupational therapy and attend the local diversional therapy groups.

Each area has a separate programme and some activities are joined. The activities plans in the rest home, hospital and secure dementia unit are sampled and confirm that a wide range of appropriate activities are provided. This includes both internal activities and regular outings for those able to attend. A scrap book of photos is sighted and provides sufficient evidence of the range of activities that are provided. These include games, exercises, entertainers and one on one.

Residents interviewed confirm that attendance at activities is voluntary, and that they can choose from the range of activities on offer. All residents have an activities plan completed on entry (sighted) and these are reviewed every six months. Current reviews are sighted in all resident records sampled and are collated using resident feedback, observation at activities and review of attendance records.

The residents in the secure dementia area are encouraged to join in on the activities being conducted in other areas of the facility. In this event staff accompany the resident to ensure ongoing safety. This is observed during the audit.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical leader interviewed, and the organisations policies, confirm that care plans are required to be formally reviewed for all residents every six months, and the existing care plan updated as required. Care plans reviews are completed by the clinical leader. These are diarised on an annual calendar (sighted) and include the same domains as the care plans. Reviews are fully documented and include current status, required changes and achievement towards goals. A review of nutrition, pressure, falls, restraint, pain, continence and activities is included.  
  
Clinical review meetings are also conducted weekly. These are attended by the senior clinical team and the quality coordinator (who is also a registered nurse). These meetings include discussion regarding any resident who has been of concern over the last week and plans are made for the coming week. A weekly focus is also identified which is then communicated to staff for sign off. Staff interviewed confirm the usefulness of the weekly focus.   
  
Daily checklists are completed by the care givers which indicate achievement in activities of daily living. Wound and infection care plans are also evaluated as and when required. Three monthly GP reviews are conducted for rest home and dementia residents (unless needed more often) and monthly GP visits for hosptial residents. All residents’ medication is reviewed three monthly. The required GP reviews are sighted within the records sampled.  
  
The District Health Board requirements are met.

The clinical leader interviewed, and the organisations policies, confirm that care plans are required to be formally reviewed for all residents every six months, and the existing care plan updated as required. Care plans reviews are completed by the clinical leader. These are diarised on an annual calendar (sighted) and include the same domains as the care plans. Reviews are fully documented and include current status, required changes and achievement towards goals. A review of nutrition, pressure, falls, restraint, pain, continence and activities is included.  
  
Clinical review meetings are also conducted weekly. These are attended by the senior clinical team and the quality coordinator (who is also a registered nurse). These meetings include discussion regarding any resident who has been of concern over the last week and plans are made for the coming week. A weekly focus is also identified which is then communicated to staff for sign off. Staff interviewed confirm the usefulness of the weekly focus.   
  
Daily checklists are completed by the care givers which indicate achievement in activities of daily living. Wound and infection care plans are also evaluated as and when required. Three monthly GP reviews are conducted for rest home and dementia residents (unless needed more often) and monthly GP visits for hospital residents. All residents’ medication is reviewed three monthly. The required GP reviews are sighted within the records sampled.  
  
The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a documented process for the management of referrals. A number of referrals to specialist services are included in the sample and confirm that referrals are made in an appropriate and timely manner. The organisation previously received a Health and Disability complaint regarding the manner in which one referral was managed and the GP interviewed confirms that processes are now in place to ensure that all referrals are followed up accordingly. This is confirmed in the resident records sampled and include referrals to the dietician, physiotherapist, mental health and specialist services.

Residents and family interviewed confirm that they are offered referrals to other health professionals as appropriate.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The clinical manager reports that transfers and exits occur either between internal services and/or to other external providers. There is sufficient evidence in the resident records that when a resident transfers from one level of care to another (within the facility) that the required re-assessments are updated/conducted. In the event the resident is transferred from, or to another facility, the required documentation is completed. This includes a copy of the current care plan. Family interviewed report they are kept informed of the need to transfer the resident if required.

The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines. Standing orders are sighted and meet the requirements of the 2012 guidelines. Standing orders have been reviewed recently by the visiting general practitioner and include problem, criteria, interventions, timeframes and maximum dose. The process for activating verbal orders is sampled and confirms that verbal orders are implemented as per the organisation’s medication policy.   
A robotics medication system is implemented. All medicines are prescribed by the GP. Medication reconciliation is completed when medication enters the facility. All medications from the pharmacy are checked on entry and a record is maintained (sighted). Medications are safely stored in medication trolley in both the rest home and hospital .Bulk supplies of medications are safely stored in the hospital dispensary and are not used for residents residing in the rest home or secure dementia unit. Routine checks are conducted for expiry dates and medication fridge temperatures are monitored. Controlled drugs are kept securely and checked regularly as required. The pharmacy has recently conducted the required six monthly stock take. Non packaged medications are labelled and dated when opened.   
  
Medications are administered by those assessed as competent to do so. Competencies for medication management are monitored and medication competency records are sighted. Two lunch time medication rounds are observed (rest home/secure unit and hospital) and confirms administration is safely maintained.

Ten medication charts are sampled. This includes medication charts from the three service areas. Medication records include suitable identification and allergies are recorded. Three monthly GP reviews are also evident in all records sampled. Accurate medication administration records are maintained and specimen signatures are documented.

There is a process for assessing the competency of residents who self-medicate their own medications. There is currently one rest home resident who self-administers medication. The required assessment and GP approval is sighted.

Medication errors are reported using the incident and accident reporting process.  
  
The District Health Board requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. There is a four week seasonal rotating menu which has been reviewed by a registered dietitian to confirm it is appropriate for the nutritional needs of the older person. Deviations from the menu are recorded. Residents interviewed are satisfied with the food. The meal service is observed on both days of the audit. Meals appear well presented and sufficient in quantity.   
  
The cook is interviewed. Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. These are displayed in the kitchen. This includes, for example, residents who are diabetic or require moulied or fortified meals.  
  
Weight is monitored regularly dependent on need. Records of weight monitoring are sighted. Where required, additional nutritional support is documented and appropriate interventions implemented. This includes referrals to a dietitian as required. The GP reviews weight charts during medical review.   
  
The cook has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained and this includes temperature monitoring. Food service audits are also conducted and include temperatures, presentation, food items served and resident comments.  
  
The District Health Board requirements are met.

Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. There is a four week seasonal rotating menu which has been reviewed by a registered dietitian to confirm it is appropriate for the nutritional needs of the older person. Deviations from the menu are recorded. Residents interviewed are satisfied with the food. The meal service is observed on both days of the audit. Meals appear well presented and sufficient in quantity.   
  
The cook is interviewed. Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms a knowledge of the dietary needs, allergies, likes and dislikes of each resident. These are displayed in the kitchen. This includes, for example, residents who are diabetic or require moulied or fortified meals.  
  
Weight is monitored regularly dependent on need. Records of weight monitoring are sighted. Where required, additional nutritional support is documented and appropriate interventions implemented. This includes referrals to a dietitian as required. The GP reviews weight charts during medical review.   
  
The cook has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers and records of temperature monitoring are maintained and this includes temperature monitoring. Food service audits are also conducted and include temperatures, presentation, food items served and resident comments.  
  
The District Health Board requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Waste management procedures sighted for general waste, disposable products, infectious waste, biomedical waste, recycled waste, sharps and food scraps. The sighted policies meet the required standard. These policies and procedures are implemented as observed at the onsite audit. The chemicals are observed to be securely stored in the laundry, cleaner’s cupboard and sluice rooms. The two cleaners and two laundry staff interviewed report that they follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation. There is appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The laundry worker/cleaner interviewed reports that they have had training in the handling of waste or hazardous substances, which is conducted by the external chemical provider and as part of the ongoing in-service education programme, last conducted June 2014.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

Building Warrant of Fitness expires 9 March 2015.

Equipment is maintained to ensure safety. Electrical tag and testing was last conducted in June 2014. The calibration of the medical equipment is last conducted in June 2014 (includes hoist, nebuliser, electric beds, sphygmomanometers, thermometer and regulator). The scales have a separate verification (which is last conducted in November 2013). The service has a planned and reactionary maintenance programme, with the building maintained in an adequate condition appropriate to the age of the building. The maintenance log notes the area of work required and is signed off when the work is completed.

The fittings and furniture installed are maintained to ensure safety and the needs of the rest home, hospital and dementia level of care residents. The physical environment is appropriate for the residents. Hand rails are installed in corridors. There is disability access at all entrances that are not at ground level. There is an ongoing maintenance and refurbishment plan for the service. The residents’ rooms sighted are personalised with the resident’s possessions. Residents are provided with safe and accessible external areas that meet their needs.

Hot water temperatures in resident areas are monitored monthly by the manager with an annual check by a plumbing service (last conducted June 2014). The temperatures sighted are within the safe temperature guidelines for aged care. The gas heating system is also checked annually by the plumbing service for a gas heater safety check.

There are no slip ramps to provide safe access to external areas. One of these ramps is under repair (to courtyard in the secure dementia unit) at the time of audit, there is an alternate entry to the internal courtyard that can be used during the repair of the ramp. The secure dementia unit is designed to promote a safe area in which the residents can wander freely.

The ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/showers/bathing facilities, conveniently located and in close proximity to each service area to meet the needs of the residents. All rooms in the rest home and hospital have either single or shared ensuites with shower and toilet in the rest home and hospital wings. All rooms have a hand basin. The rooms in the dementia unit have an ensuite with a toilet and two of these ensuites have showers. There are additional toilets and shower common areas. The toilets and showers in the common areas are clearly identified and have engaged/vacant privacy signage. The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines. There is one toilet and shower room in the secure dementia unit that has some chipped surfaces, which the manager reports is part of the ongoing maintenance programme. The facilities in the dementia unit are separated from the rest of the service. The nine residents and six family/whanau report satisfaction with the toilets and shower facilities.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All rooms are single occupancy. The rooms sighted are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents can freely move around the facility. The nine residents and six family/whanau report satisfaction with their rooms.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are lounge and dining areas throughout the facility in both the rest home/hospital and secure dementia unit. There are lounge areas in the rest home/hospital section and a separate dining room. The rest home/hospital sections have a separate family/whanau room for smaller groups. The lounge and dining areas are separated and activities in these areas do not impact on each other. There is a designated space in the hospital lounge area for larger group activities.

The specialist dementia service facilities are separated from the rest home/ hospital section, with a lounge and dining area in the dementia unit. The nine residents and six family/whanau interviewed report satisfaction with the lounge and dining facilities.

The ARC requirements are met.

##### **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:**

The cleaning and laundry services are conducted onsite by designated domestic staff. The laundry has a dirty to clean flow. The external chemical supplier conducts a monthly surveillance of the cleaning and laundry processes and sends this report to the services head office. The three domestic staff interviewed report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. It is noted that there was one bottle of chemicals on the cleaning trolley that was not labelled, this was replaced at the time of audit and is not reflective of a systemic issue. The nine residents and six family/whanau interviewed report satisfaction with the cleaning and laundry services. One resident reports that they have been at the service for over four years and in that time has never lost items of clothing that have gone to the laundry.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

Approved Fire Evacuation Scheme Status sighted. Approval provided by the Auckland Fire Region, dated 7 July 2004.

The service has adequate emergency supplies in the event of an emergency or outbreak. The manager reports there is at least three days’ supply of food and water for emergency use. There is a civil defence kit with emergency supplies; these supplies are checked monthly by the manager. In the case of mains failure the service has access to emergency lighting and gas cylinders supply for water heating, general heating and cooking

All resident rooms, bathrooms and lounge areas have a call bell system installed. There is a nurse call cord in each resident room, bathrooms, showers and ensuites. The call bell system is a pager system, with all care staff RNs and caregivers in possession of a pager. When the call bell is activated, this shows on the pager and on a panel at reception. There are additional emergency call points in the lounge areas. The response time to call bells is monitored. The nine residents and six family/whanau report that the call bell is answered in a timely manner.

The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The six caregivers interviewed demonstrate knowledge on responding to emergency situations. All senior staff have a current first aid qualification. There is least one staff member on duty at all times that has the current first aid qualification.

The service conducts six monthly evacuation training, with the last drill conducted March 2014.

The service identifies and implements appropriate security arrangements relevant to the residents at rest home/hospital level of care. The service has a secure dementia unit that is separated from the rest home/hospital section. The afternoon staff are required to close and lock the external windows and doors before it gets dark. There are two security patrols each night by an external contractor. The service has external security lighting. The six caregivers interviewed report that they feel safe and secure when working afternoon and night shifts. The nine residents and six family/whanau interviewed report they feel safe and secure at night.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

Areas used by residents and staff are ventilated and heated appropriately. There is a mix of gas and electric heating through the service. All resident-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light and ventilation. The nine residents and six family/whanau report satisfaction with the natural light, ventilation and heating.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The provider actively works to reduce the use of restraint. Sensor mats are provided for residents who are at risk of falling out of bed and additional monitoring is provided for residents who are at risk of falling when mobilising. The current restraint register is sighted and states there are 15 residents that have a restraint in use and one resident with an enabler. All restraints are bed rails for hospital residents. The one enabler has been requested by the resident and is voluntary. The restraint assessment approval process confirms that the least restrictive option is chosen and alternatives to restraint explored.

All staff receive education on the use of restraints, enablers and the management of behaviours of concern. The definition of restraint and enablers is congruent with the relevant standard. All staff interviewed are well versed in the difference between a restraint and an enabler.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The documented restraint approval process defines clear lines of accountability for restraint use. The approval group includes the clinical leader, GP, resident (if able) and family member and decisions are discussed with the quality team. There is sufficient evidence that family feedback is acted on. Three residents records sampled include the use of a restraint. The required approval is sighted in three out of three records sampled.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a comprehensive restraint assessment process. This includes the history of the resident and any previous restraint/enabler use, the type of restraint, alternatives and any further recommendations, associated risks and desired outcomes. The required assessments are sighted in three out of three resident records sampled where a restraint is in use and has been approved.

The District Health Board requirement is met.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The required assessments, approvals and monitoring is sighted in the records of residents who have a restraint in use. There are 15 residents in the hospital who have been assessed as requiring bed rails when in bed. It is reported that all these residents are medically fragile and have limited mobility. The use of bed rails is observed during the audit and sighted as safe. The clinical leader interviewed reports there have been no incident or accidents related to restraint use, and there are no such incidents sighted in the incident/accident register. All bed rails have protective covers and sufficient staff monitoring is in place. The monitoring requirements for each episode of restraint is documented and staff are observed conducting monitoring rounds for those residents who are unable to leave their bed independently.

All staff are required to complete restraint competencies and the staff restraint competency register is sighted. Staff interviewed are aware of the safety issues when a restraint is in use.

The District Health Board requirement is met.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

A three month review is conducted on all restraint use and this is evident in records sampled. Reviews include discussions on alternative options, care plans, least amount of time, impact on the resident, adequate support, sufficient monitoring and any changes required. Discussions on the number and use of restraint are also included in quality committee meetings and annual service reviews (sighted). The clinical leader interviewed reports that restraint use is frequently discussed with regard to alternative options.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The use of restraint is discussed at quality meetings. Meetings of minutes are sighted and confirm discussions on restraint are occurring. This includes a review of all restraint use. An annual review of the restraint programme is also conducted. The most recent review was conducted in January 2014. Minutes sighted report that no restraint had been required to be removed and that all restraint use was appropriate. Assessment and monitoring was reported to be appropriate and no residents had been restrained due to behaviour. There had also been no adverse events regarding restraint use in the past year.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**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:**

There is a documented infection prevention and control programme. Infection control has three components: standards and policies, adequate resources and monitoring practice. The programme is reviewed annually and was last reviewed in January 2014. The review includes a review of the coordinator role, issues, policies, professional development, communication of data, prompt action in an outbreak, audits, incidents of needle stick injuries, review of food services and a full analysis of an earlier outbreak in 2014.

The role of the coordinator is defined in policy and reviewed during the annual performance appraisal. The role includes ensuring policies are sufficient and accessible, ensuring staff education is conducted, monitoring the incidence of infections, monitoring related systems and reporting on outcomes.

Staff interviewed confirmed they have adequate resources, including personal protective equipment. Information on infection prevention is displayed throughout the facility and all staff and residents are offered flu injections.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme is implemented through a number of related activities. Activities for the prevention of infections and control of spread are suitable to the type of services provided. The clinical leader is the infection control coordinator and has the required expertise and training. The clinical leader reports that additional support is accessed from the GP, public health, laboratories and the gerontology nurse specialist if required.

The required equipment and supplies are provided and include sufficient personal protective equipment, hand sanitizer throughout the facility, sharps container, defined processing for the management of waste and contaminated products, sufficient supplies of single use items and accessible policies and procedures. The organisation also as sufficient resources to manage any outbreaks. For example there was an outbreak of gastroenteritis in early 2014. A full report and analysis of records confirms the outbreak was contained to 20 residents and over within a 48 hour period.

Infection control audits are conducted to confirm the programme is implemented as required. Completed audits are sampled.

The District Health Board requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The required infection control policies and protocols are documented. These include hand washing, standard precautions, surveillance programme, occupational health, management of infectious waste, use of antimicrobial agents, multi-resistant organisms, isolating infection precautions, outbreak management, single use items and management of devices, building/renovations and construction. Policies are written in line with the current standards and were last reviewed in April 2014.

The District Health Board requirement is met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

All staff receive education on infection prevention and control. Training is mandatory and provided at orientation and in an ongoing manner. The gerontology nurse specialist has also provided training (multi-resistant organisms and standard precautions) in June 2014. This included both care givers and registered nurses. The infection control coordinator has also attended quarterly education conducted by the local District Health Board (May 2014). This included standard precautions, multi-resistant organisms, norovirus/clostridium difficulties and scabies.

All staff interviewed confirm the provision of, and attendance, at the required infection prevention and control training.

Residents are kept informed of infection prevention and control strategies through the display of information and sufficient hand washing facilities.

##### **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:**

Surveillance requirements are documented. Monthly infection control reports are documented on infection control reports. Monthly reports include type of infection, organism, antibiotic, and date of resolution. Standard precautions are defined and infections are collated for benchmarking. A full analysis of collated data is included in the monthly quality team meetings, graphs are displayed for staff and a full report documented annually. Trends for each month are identified. Performance indicators for infection control are tracked back to 2009 and can evidence that antibiotic use has decreased by 30%.

A full analysis and report was conducted following the January 2014 outbreak. This included daily updates, symptoms and number infected and concluded with a full review of activities and corrective actions. An infection control management plan was documented

##### **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.)*