# B.J.M.H. Enterprises Limited - Killarney Rest Home

## Current Status: 16 July 2014

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

## General overview

Killarney rest home is 22 bed facility that provides rest home (11 beds) and dementia care (11 beds). Occupancy on the day of audit was four rest home residents and six residents in the dementia unit.

The owner has 13 years aged care experience and has the national certificate in the support of the older person. Killarney is the fifth aged care facility the husband/wife team have owned and they currently have a rest home/hospital facility elsewhere. One owner is on site weekly and is supported by a full time registered nurse/manager. Residents and relatives are complimentary of the care, staff and management and the medical care received.

The provisional audit was undertaken to establish the preparedness of a prospective provider to provide a Health and Disability service and to assess conformity prior to a facility being purchased.

Improvements identified at this audit were required to the following aspects of pressure area reporting, wound care management, care plan documentation and aspects of medicine management and documentation.

The owner is in negotiation to sell Killarney. There is an expected handover of a six week handover period between the existing owner and B.J.M.H Enterprises Limited. The new owner was on-site for an interview and confirmed there will be no structural changes to the building, however there are plans to re-furbish and upgrade bedrooms and communal areas in the near future. There will be no changes to current staff and the current RN/manager will remain in his role. The new owner intends to employ a qualified diversional therapist for approximately 15-20 hours per week with a plan to re-introduce community outings. The current quality and risk management system will continue. The new owner will continue to contract the aged care consultant with on-going monthly meetings.

# 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:** | B.J.M.H.Enterprises Limited |
| **Certificate name:** | B.J.M.H. Enterprises Limited - Killarney Rest Home |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Provisional Audit | | | |
| **Premises audited:** | Killarney Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 16 July 2014 | **End date:** | 16 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:** | 10 |

## **Audit Team**

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

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 13 | Total audit hours | 29 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 4 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 9 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 29 July 2014

## **Executive Summary of Audit**

**General Overview**

Killarney rest home is 22 bed facility that provides rest home (11 beds) and dementia care (11 beds). Occupancy on the day of audit was four rest home residents and six residents in the dementia unit.   
The owner has 13 years aged care experience and has the national certificate in the support of the older person. Killarney is the fifth aged care facility the husband/wife team have owned and they currently have a rest home/hospital facility elsewhere. One owner is on site weekly and is supported by a full time registered nurse/manager. Residents and relatives are complimentary of the care, staff and management and the medical care received.   
The provisional audit was undertaken to establish the preparedness of a prospective provider to provide a Health and Disability service and to assess conformity prior to a facility being purchased.

Improvements identified at this audit were required to the following aspects of pressure area reporting, wound care management, care plan documentation and aspects of medicine management and documentation.

The owner is in negotiation to sell Killarney. There is an expected handover of a six week handover period between the existing owner and B.J.M.H Enterprises Limited. The new owner was on-site for an interview and confirmed there will be no structural changes to the building, however there are plans to re-furbish and upgrade bedrooms and communal areas in the near future. There will be no changes to current staff and the current RN/manager will remain in his role. The new owner intends to employ a qualified diversional therapist for approximately 15-20 hours per week with a plan to re-introduce community outings. The current quality and risk management system will continue. The new owner will continue to contract the aged care consultant with on-going monthly meetings.

**Outcome 1.1: Consumer Rights**

Killarney rest home practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights ‘the Code’ and copies of the code are displayed in the main entrance.   
There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process.   
There are implemented policies to protect residents from discrimination or harassment. There is an open disclosure policy that staff understand. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.   
Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau.

**Outcome 1.2: Organisational Management**

The organisation has an annual business and quality/risk management plan in place with annual quality objectives. Quality, health and safety and infection control are set agenda items at management and staff meetings. Internal audits have been completed as per the audit schedule.   
Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal audits and receive meeting minutes.   
The service has policies/procedures to provide rest home and dementia level of care. All staff have completed an orientation programme. There are documented job descriptions for all positions, which detail each position’s responsibilities, accountabilities and authorities.   
There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurse hours for the level of care provided. There is a 2014 education planner in place that includes compulsory training for aged care staff.

**Outcome 1.3: Continuum of Service Delivery**

The service has a documented assessment process and resident’s needs are assessed prior to entry. There is an information pack available for residents/families/whānau at entry.

Assessments, care plans and evaluations are completed by the registered nurse manager. Residents/relatives/whanau are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available, implemented and are used to assess the level of risk and support required for residents. There is an improvement required around pain assessment. Service delivery plans demonstrate service integration and are individualised. Care plans are evaluated six monthly or more frequently when clinically indicated. Short term care plans are available for use for short term needs. There is an improvement required around interventions. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

The activities co-ordinator provides an activities programme that involves the wider community. Activities are planned to cover five days of the week. Residents in the dementia care unit have an individual plan that covers activities over a 24 hour period. There are improvements required around separate programmes for rest home and dementia residents and provision of outings.

The service medication management policies and procedures follow recognised standards and guidelines for safe medicine management practice. Controlled medication balances are checked weekly by two registered nurses and expired medications are returned to pharmacy. There is a requirement for improvement around aspects of medicine management and documentation relating to general practitioner signatures, review of medication charts, three monthly competency review for a resident self-medicating and safe storage of the medication and oversight by the registered nurse of prn medication use.

Meals are prepared on site. Food and fridge temperatures are recorded. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

**Outcome 1.4: Safe and Appropriate Environment**

There is appropriate equipment sighted to facilitate safe care for residents requiring dementia and rest home level care. The physical environment minimises risk of harm and the dementia unit is secure, homely and safe. All areas have space to manoeuvre residents with associated equipment. There is adequate equipment provided to ensure the needs of residents are met. The rest home and dementia unit have separate lounges and dining rooms. The building holds a current warrant of fitness. Electrical equipment is checked annually. Hot water temperatures are monitored. Residents are able to bring their own possessions and are able to adorn their room as desired. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan and fire drills are conducted six monthly.

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

There are comprehensive policies and procedures that meet the restraint standards. The registered nurse/manager is the restraints co-ordinators with defined responsibilities within a job description. Restraint use education is provided on orientation and is included in the annual education planner. There are currently no residents on restraint or enablers.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an Infection control co-ordinator with defined responsibilities. Reports and surveillance data are discussed at staff and management meetings. All staff receive infection control education on orientation and attend annual education. Hand hygiene competencies and internal audits are completed. The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 40 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 4 | 2 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Five of five residents files sampled did not show evidence of pain assessments. All five residents (two rest home and three dementia care) identified pain and are on pain management medication. | Ensure all residents with identified pain have pain assessments completed. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | One dementia care resident with weight loss has a documented requirement of weekly weighs which has not being completed weekly. | Ensure that all required interventions are completed as documented. | 90 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i)There is no separate programme offered for rest home residents. (ii) Rest home residents and family interviewed stated that there have been no outings for at least four weeks. | (i)Ensure that there is a separate activities programme for rest home residents. (ii) Ensure that outings for residents are provided. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)Three out of ten medication charts had no evidence of three monthly GP review. (ii)One resident prescribed XXXXX medication in 2013 for thirteen weeks is still being administered the medication and this has not been reviewed. (iii) Administration of prn medications by caregivers is not routinely checked with the registered nurse manager prior to administration and documented in the progress notes. | (i)Ensure that all residents’ medication charts are reviewed three monthly by the GP. (ii) Ensure that medications are appropriately charted by the GP. (iii) Ensure that he registered nurse manager authorises the administration of PRNs by the caregivers, and this is documented in the progress notes. | 60 |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | (i)Three monthly competency assessments have not been completed. (ii)The resident does not have a locked drawer for safe storage of the medications. | (i)Ensure that three monthly competency assessments for self-administration of medicines is completed, (ii) Ensure that residents self-administrating medicines have their medicines stored safely in a locked drawer. | 60 |
| HDS(C)S.2008 | Standard 1.4.3: Toilet, Shower, And Bathing Facilities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | One toilet does not have a hand basin. | Review the toilet to ensure hand washing facilities are within close proximity. | 180 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

The service has available information on the Code of Health and Disability Services Consumers’ Rights. Advocacy pamphlets and the code of rights in English and Maori are clearly displayed in the entrance. Three rest home residents and two relatives (one dementia and one rest home) interviewed confirmed that information has been provided around the code of rights. There is a resident rights policy in place. Code of Rights training was completed in April 2013. Discussion with five staff (two caregivers, one registered nurse, cook and activity co-ordinator) all are aware of the Code of Rights and could describe the key principles.

##### **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:**

There is a welcome information pack that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and as appropriate their advocate, enduring power of attorney or legal representative. The facility owner is the privacy officer and has completed customer services training. The facility owner and registered nurse (RN)/manager are available to discuss concerns or complaints with residents and families at any time. Residents and family members interviewed state they received sufficient verbal and written information to be able to make informed choices on matters that affect them.   
D6.2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, complaints policy, code of rights, H&D Commission and advocacy pamphlet. Advocacy brochures are readily available.

##### **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 facility provides physical and personal privacy for residents. All residents currently have their own bedrooms. There are double rooms (two in the dementia unit and two in the rest home) and residents/families consent to the sharing of rooms should this occur. During the audit, staff are observed treating residents with respect and ensuring their dignity is maintained. Staff are observed knocking on the resident’s door and waiting to be asked to enter the room. Staff interviewed are able to describe how they maintain resident privacy. Resident’s ethnicity, cultural, religious and social values and beliefs are identified on admission.   
D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Residents interviewed (three) stated staff are respectful of their belongings.   
D3.1b, d, f, i The service has a philosophy that promotes quality care, respect and friendliness within a home environment. Residents and relatives interviewed state they are involved in decisions about their care and the staff are caring, respectful and residents are treated as individuals.   
The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with two caregivers (morning shift) who work in the rest home and dementia unit described providing choice during daily cares including shower times, settling times and choice of clothes to wear.   
There is an abuse and neglect policy that is implemented. Abuse and neglect training has been attended by seven staff March 2014. Abuse and neglect is included as part of the staff orientation programme. Discussions with residents and family members are positive about the care provided.

##### **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:**

A3.2 There is a Maori care and cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a comprehensive guide that acknowledges the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori including death and dying.   
The policy includes references to other Maori advocacy services available and interpreter services. Maori staff members provide cultural support as required. The service has one Maori resident. Specific cultural wishes including whanau involvement is identified in the residents care plan.   
D20.1i The service seeks the advice of family/whanau for iwi or kaumatua involvement. Staff attended cultural safety training in April 2013. The Maori care and cultural safety policy identifies the importance of whānau. Interviews with two caregivers confirmed knowledge of Maori care guidelines for cultural safety and could describe the importance of including family in the delivery care to Maori residents.

##### **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:**

Killarney rest home has policies and procedures to guide staff practice to meet the individual ethnic, cultural, spiritual values and beliefs.   
Individual culture, values and beliefs information is gathered on admission with resident/family involvement and is integrated into residents' care plans and activity plans. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual beliefs and community links as identified in the individual care plans and activity plans. D3.1g: The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process.   
D4.1c: Care plans reviewed included the resident’s spiritual, cultural, values and beliefs social and recreational needs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Job descriptions and duties lists include responsibility of the position. The Code of Conduct and residents rights and responsibilities are included in the orientation pack with on-going education. There are policies in place to guide staff practice.   
Staff are observed to be professional within the culture of a family environment. The RN/manager works within professional boundaries as defined by Nursing Council.  
Interviews with staff (two caregivers, and activity co-ordinator), RN manager and the facility owner could describe how they build a supportive relationship with each resident. Residents interviewed (three rest home) stated they are treated fairly and with respect

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

The owners (two) and management team are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents and family interviewed state they are very happy with the level of care provided.   
The service has implemented policies and procedures that are developed and reviewed by an external aged care consultant. The policies and procedures meet legislative requirements. New or reviewed policies and procedures are discussed at staff meetings and staff sign to state they have read the new/reviewed policy/procedure. Caregivers interviewed state there are caregiver guidelines and care plans in place to guide the delivery of care to residents. They receive a verbal handover and written shift handover for every shift that details significant events. A handover book is used to raise any non-urgent problems.   
There is an orientation programme in place and staff complete competencies relevant to their role. Clinical audits completed include (but not limited to) medication management, privacy and rights, admission and post admission, non-restraint, manual handling, hygiene and care planning. Issues are identified and corrected as they arise.  
  
A2.2 Services are provided that adhere to the health & disability services standards. There is an implemented quality improvement programme.   
17.7c There are implemented competencies for the RN/manager and caregivers. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The owner and RN/manager promote an “open door” policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Information is provided in formats suitable for the consumer and their family. There are two monthly resident meetings held with opportunity for feedback on the services. Families and residents receive newsletters (sighted) that keep them informed on all matters that affect them.  
Open disclosure is practiced. Seven of seven accident/incident forms sampled evidenced the family had been notified of the incident/accident. Staff attended open disclosure training November 2013 provided by the aged care consultant.   
  
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Relatives and residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss information and the admission agreement with management.   
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b Family/whanau interviewed (one dementia, one rest home) state they are notified promptly of any changes in their relatives health.  
D11.3 The information pack is available in large print and advised that this can be read to residents. The code of rights is in Maori. Interpreter services are available.

##### **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:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Consent is obtained for release of health information, photograph for identification and display, transport, on-going cares and care choice and release of information to family or representative. Written consent is obtained for specific procedures. The use of an interpreter is offered. Two caregivers interviewed are able to describe resident choice and informed consent when delivering resident cares.

Advance directives for competent residents are appropriately signed. There is evidence of GP discussion with relative/enduring power of attorney where the resident is deemed incompetent to make a decision and resuscitation is not medically indicated. Advance directives are reviewed by the GP and residents are informed of their choice to withdraw or change their advance directive status. Staff (seven) attended training on enduring power of attorney, resuscitation and advance directives in March 2014.

D3.1.d: Discussion with two family members (one dementia, one rest home) identifies that the service actively involves them in decisions that affect their relative’s lives. Advanced directives are completed for residents who are competent to make the decision.

D13.1: There were five signed admission agreements

##### **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:**

Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are available at the reception area of the home. Resident advocates are identified on admission. Interviews with three rest home residents confirmed that they are aware of their right to access advocacy. Staff interviewed are aware of the resident’s right to advocacy services and how to access the information.   
D4.1d; Discussion with two family identified that the service provides opportunities for the family/EPOA to be involved in decisions. Staff (five) attended advocacy training November 2013.   
ARC D4.1e, The resident files includes information on resident’s family/whanau and chosen social networks

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a policy to maintain links with family and community and this is identified with the resident on initial assessment and development of the activity care plan. Residents are supported to attend their individual community activities and functions as appropriate. Regular outings have not occurred in recent months (link 1.3.7.1). Visiting arrangements are suitable to residents and family/whānau. Families interviewed (two) state they are always made to feel most welcome when they visit.   
D3.1h; Discussion relatives confirm that they are encouraged to be involved with the service.   
D3.1.e. Discussion with staff and relatives state residents are supported and encouraged to remain involved in the community and external groups such as churches and community groups.

##### **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 in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The owner and RN/manager share the responsibility for complaints management. There is a current complaints register. There is evidence of verbal concerns (one telephone call in June 2013) and two written concerns (received July 2013) have been addressed following the complaints procedure in 2013. All complaints have been resolved to the satisfaction of the complainant. There is evidence of an investigation process, complaints follow-up and corrective action process and letter of outcome of investigation sent to the complainant. Advocacy is offered. An advocate has attended a family meeting. There have been no complaints in 2014 to date.   
Where appropriate surveys or internal auditing is completed as part of the monitoring process. Compliments/concerns/complaints brochure/forms are readily available. There is a compliments and concerns/complaints box at the front entrance. Staff interviewed are knowledgeable in the complaints and concerns process.   
D13.3h. A complaints procedure is provided to residents within the information pack at entry. Outcomes of the concerns/complaints are discussed at the management meetings and staff meetings as appropriate. Discussion with three residents and two relatives confirmed they were provided with information on complaints and complaints forms and are comfortable approaching management with any concerns/complaints   
E4.1biii.There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:   
1. Minimising restraint.  
2. Behaviour management.  
3. Complaint policy

##### **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:**

Killarney rest home is 22 bed facility that provides rest home (11 beds) and dementia care (11 beds). Occupancy on the day of audit are four rest home residents and six dementia care residents.   
The owner/manager has 13 years aged care experience and holds the national certificate in the support of the older person. Killarney is the fifth aged care facility the husband/wife team have owned and they currently have a rest home/hospital facility elsewhere. Previously owned facilities have also been at rest home/dementia levels of care. The owner visits weekly and is supported by a RN/clinical nurse leader who has recently been appointed RN/manager (May 2014). The RN/manager is on-site Monday to Friday and available on call. An accountant is employed for payroll and accounts.   
The RN/manager has been with the service December 2013 and provide clinical leadership for the caregivers and manage daily operations. He has had 17 years as an RN in the armed services, seven years as a duty manager with the DHB and more recently up skilled as an RN ”on the floor” including working as a needs assessor.   
The 2013 business plan/quality and risk management plan from June to December 2013 has been reviewed with achievements including (but not limited to); environmental improvement of the outdoor dementia unit with brightly painted furniture and raised gardens with herbs, upgrade of furniture, separate rest home and dementia care dining rooms. The 2014 business/quality plan clearly identifies the purpose, scope, values and direction of the organisation. The owners/manager (governance) and staff are committed to the organisations mission statement “We aim to provide a quality environment in which the frail elderly and/or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed.” Aims identified for 2014 include ongoing Aged Care Education modules towards national certificate in the support of the older person, beautify external areas, purchase chair scales (when resident numbers reach 16), upgrade the dementia lounge and furnishings and provide outings.   
The potential new owner (non-clinical) operated her own business for three years before purchasing (2007) and operating a 14 bed rest home in the Auckland region for seven years. The rest home was sold in February to enable the new owner to re-locate in the Bay of Plenty region. The new owner holds a general management certificate for hospitality and has attended at least eight hours of education relevant to the role through attendance at DHB forums and study days. The new owner has future plans that includes refurbishing of bedrooms and communal areas (painting and carpet quotes are being obtained), marketing and advertising including an open day once refurbishment has been completed and establishing links with district health board key personnel and primary health providers. The current quality and risk management system will continue. There will be a six week handover period and this is confirmed by the current owner on interview. The new owner will continue to contract the aged care consultant with ongoing monthly meetings. This was confirmed by the aged care consultant who is on site the day of audit. The RN/manager will remain in his role. The new owner intends to employ a qualified diversional therapist for approximately 15-20 hours per week with a plan to re-introduce community outings.   
  
E2.1: The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.  
ARC,D17.3di: The facility manager has maintained at least eight hours of professional development annually relevant to his role including DHB meetings and provider forums, InterRAI training and mental health services study day (four hours).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The current owner visits the site weekly. The RN/manager communicates with the owner daily at other times. A casual RN covers in the absence of the RN/manager.   
The new owner intends to be a “hands on” operator and on-site at least four days a week.   
D19.1a; A review of the documentation, policies and procedures and from discussion with six staff identified that the service operational management strategies, quality programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality

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

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

**Attainment and Risk:** FA

**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:**

There are organisational policies to guide the facility to implement the quality management programme including (but not limited to); quality assurance and risk management programme, management responsibilities, health and safety, hazard management and infection control responsibilities and internal audit schedule. There is a set meeting agenda that includes quality assurance, quality improvements, health and safety, hazards, restraint, medication errors, infection control, internal audit outcomes, concerns and complaints, trends and corrective actions. Staff and management meeting minutes are sighted.   
  
Four staff interviewed state they are well informed and receive quality and risk management information such as accident incident statistics and infection control statistics. One caregiver (interviewed) is the health and safety representative, has attended training and is responsible for environmental safety. The health and safety representative provides monthly reports at the staff and management meetings. Staff use a hazard report form to report identified hazards. The hazard register is current and includes hazard identification for each service.   
The owner/manager has implemented a comprehensive audit schedule covering each area of service delivery including (but not limited to); infection and cleaning – June 13, admission – July 13, complaints – August 13, recreation – September 13, education – October 13, safety audit – December 13, food services – January 14, medicine management – January 14, manual handling – February 14, laundry – March 14, hand hygiene – May 14 and fire evacuation audit – July 14. There is audit compliance against the schedule for 2013 and 2014 to date. Corrective actions are identified and documented on the audit form and signed off as addressed. Audit outcomes and quality improvements are discussed at the staff and management meetings (minutes sighted).   
   
Clinical guidelines are in place to assist care staff with such issues as incontinence, challenging behaviour, falls prevention, nutrition and hydration, skin care and wound management and pain management. Policies and procedures are purchased through an aged care external consultant who visits the service monthly and ensures document control is maintained as per the document review chart.   
  
The relative/resident survey (covers all areas of the service) has been sent out March 2014 with one response to date which is complimentary about the service  
D19.3: There is an H&S and risk management programme in place including policies to guide practice.   
D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of sensor mats. An annual analysis of falls for 2013 has been collated and identified a higher than expected fall rate included two serial fallers. There have been no falls with fractures.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

As part of risk management plan there is an accident/incident policy, which includes reference to open disclosure, level of seriousness and the responsibility for investigation, cause and contributing factors, corrective actions and quality improvements. Monthly data collection of accident/incidents is completed and includes (but not limited to): falls, skin tears, bruises, medication and behavioural incidents. When an incident occurs the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. The RN/manager on duty/on call completes a clinical assessment and identifies preventative and corrective actions. Neurological observations post unwitnessed fall are sighted. Six if six accident/incident forms (five from May and one from June 14) evidence family/whanau notification. Family interviewed (one rest home and one dementia) state they are always contacted if there have been any incidents. All incidents/accidents are signed off by the RN/manager who conducts a further investigation if required. The two care staff interviewed state they are informed of any falls and significant events at shift handovers and receive information and data at staff meetings.   
  
D19.3b: There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action.   
D19.3c: The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurse (RN)/manager, three caregivers and one cook). The recruitment and staff selection process requires that reference checks are completed prior to employment to validate the individual’s qualifications, experience and suitability for the role. The RN/manager has a current practicing certificates. Annual practicing certificates are sighed for pharmacist, GP’s and dietitian. All files evidence a signed job description. Employment contracts are in place for all staff files sampled. The owner and RN /manager has a schedule in place to ensure staff appraisals are completed annually in August.   
There is an orientation programme that includes organisational structure and policies and general information for staff. Senior caregivers orientate new staff to their area of work. Five of five files sampled (includes newly appointed caregiver) have completed orientation records in their file. Competencies relevant to their role are completed and linked to the annual performance appraisals. The RN/manager and caregivers responsible for medication administration complete annual competencies and attend annual education session last provided December 2013. There is a documented in-service programme for education that covers compulsory requirements including standard precautions, safe manual handling, cultural awareness training, and advocacy, code of rights, civil defence, falls prevention and pain management, cleaning and laundry and chemical safety.   
D17.8: Eight hours of staff development or in-service education has been provided annually.   
E4.5f: Six of six caregivers employed in the dementia unit have completed the required dementia standard.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Staffing rosters were sighted and there are an adequate number of staff on duty to meet the resident’s needs on different shifts. There is one caregiver per duty for the rest home and the dementia unit. There is an activity person/caregiver also on duty the morning shift. The caregivers work 12 hour shifts from 8am to 8pm and 8pm to 8am. In the weekends there are two caregivers on duty from 8am to 8pm.   
The owner and RN//manager are on duty Monday to Friday. The RN/manager is on-call. There are two staff members who live on site (activity/caregiver and cook) who are readily available to provide assistance if required.   
Caregivers undertake laundry and cleaning duties. There is a cook on duty 7am -1pm daily.   
  
There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Three rest home residents interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly.  
Family members (one dementia and one rest home) interviewed report there appears to be sufficient staff on duty at all times.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record.   
Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in the secure staff office.   
Care plans and notes are legible and signed and dated by the RN. Individual resident files demonstrate service integration with allied health notes and medical notes.   
D7.1 Entries are legible, dated and signed by the relevant caregiver or RN/manager including designation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry, all potential residents have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family/whanau are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. There is an admission procedure in place and admission documentation which includes next of kin details. Information gathered at admission is retained in resident’s records. The registered nurse manager interviewed was able to describe the entry and admission process. Residents (three) and family members (one dementia and one rest home) state they received sufficient information on the services provided and had the opportunity to discuss the admission agreement with the manager.

Three of three residents (from the rest home) and two of two family/whanau (one rest home, one dementia) confirmed on interview that they or their family/whanau had received information prior to admission and discussed the admission with the registered nurse manager.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Five admission agreements sighted are all signed.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Three residents who are being provided with specialist dementia services were sampled and all included a needs assessment which identified them as requiring specialist dementia care.

##### **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 service has accepting/declining entry to service policies. Pre-approved residents seeking admission are not declined, providing there are vacant beds. The resident and or family/whanau are informed of the reason for declining entry. Reasons for declining entry would be if there were no beds available or the service cannot provide the level of care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident’s admission and assessment procedures. The registered nurse manager provides clinical oversight.

D16.2, 3, 4: Five of five resident records sampled (two rest home and three dementia care), identified that an assessment was completed within 24 hours of admission. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, outcomes of risk assessment tools, GP health records and letters, allied health notes, resident/family/whanau participation and involvement, provide the basis for the initial support care plan. Five of five files sampled had long term care plans completed within three weeks. Care plans are developed by the registered nurse manager and amended when or if the health of the resident changes.

D16.5e: Five of five resident records contained evidence of a GP review within two working days. The GP has assessed five out of five residents sampled as stable and to be seen 3 monthly unless otherwise indicated. The GP confirmed on interview confidence in the service and is available on call for the service.

Relatives and residents advised on interview that assessments were completed in the privacy of their single room.

There is a verbal handover period between the shifts. A communication book is maintained. Significant events are reported to the registered nurse manager and documented in progress notes. Progress notes are written on each shift. Two caregivers and the registered nurse manager could describe the hand over procedure.

Tracer methodology; Rest home:

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

Tracer methodology; Dementia:

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:** PA Low

**Evidence:**

Residents are assessed on entry to the service. The registered nurse manager completes an assessment within 24 hours of admission. A range of assessment tools is completed on admission if applicable including (but not limited to); a) resident food preference/mini nutritional assessment b) falls risk, c) Braden pressure area risk assessment, d) continence and bowel, e) wound assessment, f) restraint assessment and g) behaviour assessment. Five of five residents files sampled did not show evidence of pain assessments. This is an area requiring improvement. The activities coordinator contributes to the process of assessment. The GP assesses the resident within 48 hours of admission. Notes by GP and allied health professionals are evident in resident’s files, significant events, communication with families and notes as required by the registered nurse manager. Information obtained and outcomes of the assessment process is used to develop the care plan. Family/whanau members interviewed felt they are kept well informed and are involved in all aspects of care for their family/whanau member.

Three of three rest home residents interviewed report being well informed about cares planned for them.

ARC E4.2; Three of three residents files sampled from the dementia unit had individual assessments that included identifying diversional, motivation and recreational requirements.

E4, 2a Three of three resident’s files sampled for residents receiving specialist dementia services had challenging behaviour assessments completed.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Residents are assessed on entry to the service. The registered nurse manager completes an assessment within 24 hours of admission. A range of assessment tools is completed on admission if applicable including (but not limited to); a) resident food preference/mini nutritional assessment b) falls risk, c) Braden pressure area risk assessment, d) continence and bowel, e) wound assessment, f) restraint assessment and g) behaviour assessment.

**Finding:**

Five of five residents files sampled did not show evidence of pain assessments. All five residents (two rest home and three dementia care) identified pain and are on pain management medication.

**Corrective Action:**

Ensure all residents with identified pain have pain assessments completed.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The registered nurse manager develops the long term care plan from information gathered (from staff and family/whanau involved in their care) over the first three weeks. Five of five resident files sampled have been evaluated six monthly. Medical records are maintained by the general practitioner and significant events, communication with families/whanau and notes (as required) are documented in progress notes.

E4.3 Three of three residents receiving dementia services have records that identify current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k: Short term care plans are available for use in changes of resident health status. Short term care plans sighted for skin tear, fall and urinary tract infection.

D16.3f: All five of five resident records reviewed identified that family/whanau are involved.

Three rest home residents and two family/whanau members confirm that they are involved (where appropriate) in the development and review of service delivery plans.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service provides services for residents requiring rest home and dementia level of care. Individualised care plans are completed by the registered nurse manager. When a resident's condition alters, the registered nurse manager initiate a review and if required, GP or specialist consultation.

The two caregivers and one registered nurse manager interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including shower chairs, transfer belts, sensor mats, wheelchairs, gloves, aprons and masks.

Residents and family/whanau members interviewed confirm the resident’s needs are being met. Strategies for the provisions of a low stimulus environment could be described by staff for residents living in the dementia unit.

Continence products are available and resident files include a urinary continence assessment and bowel management. Specialist continence advice is available as needed and this could be described by the registered nurse manager. Continence management in-service has been provided in September 2013.

Residents’ weight is recorded on admission and monitored monthly. One dementia care resident with weight loss has a documented requirement of weekly weighs which was not evidence as being completed weekly. This is an area requiring improvement. Stand on scales are available and have been calibrated.

D18.3 and 4. Dressing supplies are available and a treatment room is stocked for use. There are currently no residents with wounds. Comprehensive wound assessments and evaluation forms are available for use.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service provides services for residents requiring rest home and dementia level of care. Individualised care plans are completed by the registered nurse manager. When a resident's condition alters, the registered nurse manager initiate a review and if required, GP or specialist consultation.

**Finding:**

One dementia care resident with weight loss has a documented requirement of weekly weighs which has not being completed weekly.

**Corrective Action:**

Ensure that all required interventions are completed as documented.

**Timeframe (days):** 90 *(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:** PA Low

**Evidence:**

There is an activities coordinator employed for 25 hours Monday to Friday who coordinates the activities programme. She has been employed in the role for four weeks. The activity co-ordinator has completed all of her ACE modules and has experience as a senior caregiver for the last five years at another aged care service. The activities coordinator also works as a caregiver at the service. Activities are varied and include activities on site and visits from the local community such as church groups. The residents are encouraged to maintain previous community links. Family/whanau are encouraged to participate. On or soon after admission, a social history is taken and information from this is added into the activities care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and daily progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is one activities programme offered in the dementia lounge. Individual activities can also be accommodated if residents prefer this option. There is no separate programme offered for rest home residents. This is an area requiring improvement. Each dementia care resident has an activity plan on their record which lists the range of activities that can be offered over a 24 hour period. All rest home residents have an individual activity plan that reflects their interests and hobbies. The programme is designed to be provided by caregivers in the absence of the activities coordinator and the content reflects the resident group’s interests and abilities, including a range of physical, cognitive, social activities. Examples from the programme include exercises, board games floor games newspaper readings, bingo, singing, quiz’s, DVDs, celebration of special occasions, happy hour and nail care. There is one volunteer helping with activities one day per week. The service has its own vehicle that can transport six residents. The activities coordinator has a first aid certificate. Rest home residents and family interviewed stated that there have been no outings for at least four weeks. This is an area requiring improvement.

On the day of audit all residents were observed being actively involved in the dementia unit lounge with activities provided by the coordinator. Three of three rest home residents interviewed stated that were satisfied with the activities offered and that they are given a choice to participate but would like to have more outings. The two family/whanau interviewed stated they would like to see more outings provided.

##### **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:** PA Low

**Evidence:**

Activities are varied and include activities on site and visits from the local community such as church groups. The residents are encouraged to maintain previous community links. Family/whanau are encouraged to participate. On or soon after admission, a social history is taken and information from this is added into the activities care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and daily progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan.

**Finding:**

(i)There is no separate programme offered for rest home residents. (ii) Rest home residents and family interviewed stated that there have been no outings for at least four weeks.

**Corrective Action:**

(i)Ensure that there is a separate activities programme for rest home residents. (ii) Ensure that outings for residents are provided.

**Timeframe (days):** 90 *(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:**

Evaluation timeframes are specified in policies and procedures. Initial care plans were evaluated by the registered nurse manager in five of five files sampled. There is documented evidence of resident/elative/whanau participation (as appropriate) in the evaluation of care plans. There are primary caregivers for residents and caregiver confirmed on interview they are involved in the care planning and evaluation process with the registered nurse manager for their resident.

D16.4a Care plans are evaluated by the registered nurse manager six monthly or when changes to care occurs for residents in the rest home and dementia unit. Staff document progress in each residents clinical records at the end of each shift and as changes occur. A three monthly review by the medical practitioner occurs for all medically stable residents or more frequently if a resident's health is considered not medically stable. A medication review occurs at least three monthly to ensure an on-going supply of prescription medicines (confirmed in review of five of five clinical records).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. Referral documentation and communications are maintained on resident files.

D 16.4c Staff are aware of the need to refer residents to the NASC for re-assessment should there be a significant change in the resident's level of need and those needs can no longer be met by the service.

D 20.1 Discussions with the registered nurse manager identified that the service has access to primary care and specialist medical services including specialist mental health for older person’s services, dieticians, wound care nurse specialists, and physiotherapist through the DHB.

##### **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 service has transfer and discharge procedures in place (confirmed in document review and in discussions with the registered nurse manager). Inter-facility transfers are planned are coordinated through NASC agencies and in consultation with the resident and their family/whanau as appropriate. All relevant information is documented and communicated to the receiving health provider or service. Records are transferred on formal request. There is a verbal handover as appropriate and follow up as necessary. The discharge process is documented in the resident records. Transportation of client’s policy includes involvement of families/whanau, staff accompanying, emergency department by ambulance, and resident consent for discharge/transfer transportation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is a system of medicine management in place to guide staff. The system includes prescribing, dispensing, checking on delivery, administration of medicines, review, storage, disposal, self-administration, medicine reconciliation, and controlled medicines. The robotic system of packaging of tablets is used. Other medicines are supplied in pharmacy marked bottles or packages. Medications are checked on delivery by the registered nurse manager. The medicines are stored in a locked area when not in use. One resident (rest home) is self-administering medicines at the time of audit. Three monthly competency assessments reviews had not been completed and the resident does not have a locked drawer for safe storage of the medications. These are areas of self-medication requiring improvement. Medication charts are pharmacy generated. Three out of ten medication charts had no evidence of three monthly GP review. One resident prescribed XXXXX medication in 2013 for thirteen weeks is still being administered the medication and this has not been reviewed. This was checked with the pharmacy and GP on the day of the audit and confirmed that the medication is to remain current and that the medication chart is to be reviewed. Administration of prn medications by caregivers is not routinely checked with the registered nurse manager prior to administration and documented in the progress notes. There are improvements required around GP three monthly reviews, correct prescribing of medication and authorisation from the registered nurse manager for caregivers to administer prn medications as per policy. There is a locked safe within a locked cupboard for the safe keeping of controlled drugs. A controlled drug register is available. Currently there are no residents on controlled drugs. Controlled drugs returned to the pharmacy show a nil balance in the controlled drug register. The registered nurse manager (interviewed) is aware requirements of a weekly stock should there be controlled drugs be in use. Allergies are noted by the dispensing pharmacy on all medicine administration sheets. The caregivers responsible for medication management complete annual medication competencies and education (March 2014) as verified in staff records. The registered nurse manager has completed a medication competency. Staff who administer medicines sign the signing register on each medicine administration chart supplied by the pharmacy. PRN medicines are charted with an indication for use. PRN medications are dated and timed on administration. The caregiver is observed signing for medications at the time of administering the drugs. One eye drop currently in use is dated (sighted). Residents interviewed state that they receive their medicines in a timely manner.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is a system of medicine management in place to guide staff. The system includes prescribing, dispensing, checking on delivery, administration of medicines, review, storage, disposal, self-administration, medicine reconciliation, and controlled medicines. The robotic system of packaging of tablets is used. Other medicines are supplied in pharmacy marked bottles or packages. Medications are checked on delivery by the registered nurse manager. The medicines are stored in a locked area when not in use.

**Finding:**

(i)Three out of ten medication charts had no evidence of three monthly GP review. (ii)One resident prescribed XXXXX medication in 2013 for thirteen weeks is still being administered the medication and this has not been reviewed. (iii) Administration of prn medications by caregivers is not routinely checked with the registered nurse manager prior to administration and documented in the progress notes.

**Corrective Action:**

(i)Ensure that all residents’ medication charts are reviewed three monthly by the GP. (ii) Ensure that medications are appropriately charted by the GP. (iii) Ensure that he registered nurse manager authorises the administration of PRNs by the caregivers, and this is documented in the progress notes.

**Timeframe (days):** 60 *(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:** PA Moderate

**Evidence:**

One resident (rest home) is self-administering medicines at the time of audit.

**Finding:**

(i)Three monthly competency assessments have not been completed. (ii)The resident does not have a locked drawer for safe storage of the medications.

**Corrective Action:**

(i)Ensure that three monthly competency assessments for self-administration of medicines is completed, (ii) Ensure that residents self-administrating medicines have their medicines stored safely in a locked drawer.

**Timeframe (days):** 60 *(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 manaegment 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:**

There are safe food handling policies and food management policies and procedures. All food is cooked on site by the cook on duty providing 'home style' cooking. The service has a small but workable kitchen. The cook has been employed for one month, has a qualification in cooking and a background in cooking for five years. The cook is employed full time and works 7.30am-1pm and then 4pm-6pm.

D19.2 The cook has completed food handling certificates NZQA unit standards 167 and 168 July 2014.

The menu is a four week rotating/summer and winter menu developed by a dietician and last reviewed September 2013. The menu allows for seasonal foods, variation and includes festive occasions. Diets are modified as required. Residents are supported to eat independently and appropriate utensils are available as required. Residents requiring assistance with meals and fluids are assisted by caregivers. All residents have a nutritional profile developed on admission which is reviewed six monthly. Information around resident likes, dislikes, special requirements and allergies is available in the kitchen.

Residents are observed to be enjoying their meals. There is a separate dining room for rest home residents and one for the dementia care residents. The sliding doors between the two dining rooms are opened up for the serving of the meals only. Safe hand hygiene practices are observed and there are instructions to caregivers to ensure the hands of dementia unit residents are washed and dried prior to meals.

Kitchen fridge, food and freezer temperatures are monitored and documented daily. Chemicals are stored safely in the kitchen.

Three of three rest home residents interviewed confirmed the food was good, served at the right temperature and the cook accommodates their likes and dislikes. Two family/whanau members are complimentary about the meals provided for their relative.

D15.2b: The food service reflects the nutritional requirements of the older person and is served at appropriate times throughout the day with the main meal served at lunch. Staff have access to the pantry after hours if required.

E3.3f, Additional nutritious snacks are available over 24 hours for residents in the specialist dementia unit including sandwiches, fruits, cheese and crackers and home baking.

##### **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:**

There is a waste management policy and procedure that outlines processes. Staff interviewed (two of two caregivers, the registered nurses) state that they would report any incidents or accidents involving infectious material, body substances or hazardous substances if they occurred.

A comprehensive emergency plan is available to staff which included hazardous substances. Staff orientation includes chemical safety. Chemical safety training was provided in March 2014. All chemicals are supplied in correctly labelled containers which includes information on safe use. There are safety data sheets available.

Personal protective equipment is available for use by staff (eg plastic aprons and gloves). Instructions for the use of personal protective equipment (PPE) are included in policies and procedures. The correct use of PPE is included in orientation and through annual training.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a current building warrant of fitness which expires on 13 August 2014. The facility is an older style building which is built on two levels. The lower level contains staff only offices and storage areas. The downstairs stairway is located within the rest home and has a safety gate at the top. The upper level which is accessed from the street, includes the living areas for all residents. It contains accommodation for 11 rest home residents and 11 dementia care residents in separate units. Reactive and preventative maintenance takes place. Hot water monitoring is completed monthly with temperatures stable between 43 to 44 degrees Celsius. Electrical tagging is completed and current. Smoking is not permitted within the building and there is designated outside areas for smoking for residents and staff

The centre of the facility is dedicated to the specialist dementia service and is a secure environment. This area contains the larger of the two lounges, the dementia dining, main kitchen and nine bedrooms (includes two shared rooms). The dementia unit has an area of differing floor levels that has safe ramp access and handrails in place.

E3.3e: Residents in the dementia unit (and their visitors) may use their bedrooms for privacy when required. Outdoor areas provide low stimulus and quiet areas.

E3.3d The living and dining arrangements of the subsidised residents receiving specialist dementia services are separate from the living and dining room facilities for rest home residents.

E3.4.c: There is a secure outdoor paved area for use by residents in the dementia service, which includes a space for smokers. There is a ramp access to the area from the main floor. The external shed in this area is gated and locked.

E3.4d: The lounge area in the dementia unit is designed so that space and seating arrangements provide for individual and group activities. On the day of audit the lounge was being used by the residents for activities.

D15.2e: Rest home residents have access to an outside grassed area, which borders the road on both streets (the property being located on a corner section. The outdoor area is tidy on the day of audit.

D15.3b: There is adequate equipment available for the rest home, hospital and dementia unit. Interviews with caregivers and the registered nurse confirmed there was adequate equipment including, stand on scales and pressure area resources. Clinical equipment has been calibrated.

D 15 3c: There are sufficient and safe storage facilities for equipment and medicines.

Corridors have hand rails. Consideration is given to residents when purchasing new furniture/equipment.

##### **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:** PA Low

**Evidence:**

There are adequate numbers of toilets and bathrooms throughout the facility in both the rest home and dementia unit (see # 1.4.3.1). In the rest home there are four rooms that have shared access to a toilet and hand basin. Communal toilets and bathrooms have appropriate signage. In the dementia unit there are two toilets and two showers for a maximum of 11 residents and all toilets/bathrooms have signs and privacy locks. One communal toilet in the dementia unit does not have ready access to a hand washing basin. This has been reviewed by a plumber in regards to installing a hand basin. The owner has sought plumbing advice and the installation of a basin will reduce the space within the toilet. For infection control preventive measure a hand sanitizer has been placed outside the toilet and residents are supervised to the nearest hand basin for hand washing. There is an improvement required to ensure a hand basin is within close locality to the toilet. The dementia unit has two bedrooms with shared bathroom facilities.

The location of the toilet facilities are easily accessible from the communal areas. Flooring, fixtures and fittings are appropriate. All communal toilets have hand washing and drying facilities (exception #1.4.3.1). All bedrooms have access to hand basins either in the room or in shared bathroom.

##### **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:** PA Low

**Evidence:**

One communal toilet in the dementia unit does not have ready access to a hand washing basin. This has been reviewed by a plumber in regards to installing a hand basin. The owner has sought plumbing advice and the installation of a basin will reduce the space within the toilet. For infection control preventive measure a hand sanitizer has been placed outside the toilet and residents are supervised to the nearest hand basin for hand washing.

**Finding:**

One toilet does not have a hand basin.

**Corrective Action:**

Review the toilet to ensure hand washing facilities are within close proximity.

**Timeframe (days):** 180 *(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:**

The bedrooms are of sufficient size to be able to safely move around the bedroom with the use of mobility aids and allow a degree of personal space. Residents in the rest home can be transferred to an emergency trolley if necessary. Corridors and walkways allow for careful manoeuvring of wheelchairs and equipment as required. The residents in the dementia unit would be transferred in a wheelchair as required. There are two bedrooms in the dementia unit that are double rooms if required. All residents within the rest home and dementia unit have their own room on the day of audit. Residents are able to bring their own possessions including furniture to their bedroom. There is personal adornment in all rooms viewed including the rooms in the dementia unit. Flooring in the bedrooms is either carpet or vinyl.

E3.3b:& E3.3c Residents in the specialised dementia unit were not sharing bedrooms on the day of audit.

##### **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:**

The rest home has a small lounge area for its residents and a small separate dining room. Single bedrooms and an outside area provide space for rest home residents to relax. The dementia unit has a larger lounge and dining room adjacent to the kitchen.

The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance/mobility aids throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required.

On the day of audit all four rest home residents had their own bedrooms. The rest home residents have access to their own dining room space.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit has a lounge and a dining area.

D15.3d; Seating and space is arranged to allow both individual and group activities to occur.

E 3.4d Seating and space in the dementia unit lounge is arranged to allow both individual and group activities to occur. There is space to allow freedom of movement while promoting safety for those that wander.

##### **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 facility has housekeeping and laundry policies and procedures and ensures all cleaning and laundry services are maintained and functional at all times. All laundry is completed on site. Laundry and cleaning audit results are discussed at staff meetings and any issues followed up. The laundry has separate clean and dirty areas and instructions are displayed on the walls. There is a commercial washing machine and commercial dryer for use as required. Additional soaking treatments occur for soiled laundry. The facility, including the laundry, was clean on the day of the audit. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The service has a separate cupboard for the storage of cleaning and laundry chemicals. There is a policy around chemical storage. All chemicals sighted were appropriately labelled. Safety data sheets are available in folders. Chemicals are stored in locked areas. Aprons, gloves and protective goggles are readily available.

##### **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:**

There are policies and procedures in place for emergency management. There is an approved fire evacuation scheme dated 9 July 2009. Six monthly fire drills are held. All fire extinguishers have been checked in March 2014. An external contractor conducts monthly fire testing checks. All caregivers and activity co-ordinator have current first aid certificates. The RN/manager is registered to attend a first aid course 23 July 2014. There is an appropriate call bell system in all bedrooms, communal areas and toilets. Call bells show up outside of the resident bedrooms and sound, on the main panel within the dementia unit and are heard throughout the facility. An intercom system is also available to summon assistance if required. There is call bell access to the front entrance. Visitors and rest home residents can freely exit the facility. There is controlled and secure entry and exit from the rest home into the dementia unit. There are civil defence supplies including (but not limited to); batteries, torches, radio, disposable plates and other supplies. The service has 10 x 25 litres of water storage. A barbeque is available for an alternative cooking source. There is at least three days of food available in the event of an emergency. Staff attended training in security and emergencies in February 2013.

##### **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:**

Living areas and resident bedrooms have adequate light and are appropriately heated and ventilated. All resident designated rooms had a window that provided both natural light and view to the outside. Heat pumps in the dementia unit are used to ensure warmth and ventilation. There are electric panel heaters in the rest home area. All areas are warm and well ventilated on the day of the audit.

##### **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:**

There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The RN/manager is the restraints co-ordinator and has defined responsibilities for restraint minimisation and safe practice.   
The service currently has no residents an enabler or restraint. Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies and dementia course modules. Restraint and challenging behaviour was attended by seven staff April 2013 and challenging behaviour in service was held December 2013.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The scope of the infection prevention and control programme policy are available. There is an infection control programme contained within the IC policy and procedure manual that is appropriate for the size and complexity of the service. The programme includes activities such as hand hygiene, internal auditing, education and surveillance. The 2013 infection control has been reviewed and a 2014 programme is in place. There is an analysis report for the period June to December 2013. The RN/manager is the infection control co-ordinator. The overall responsibility for infection control is written into the infection control programme and there is a job description for the infection control co-ordinator. Infection control is a set agenda item at the management and staff meetings.   
Four staff interviewed state they receive the monthly reports and are aware of trends, corrective actions and quality initiatives relating to infection control activities. The RN/manager reports any significant events as necessary to the owner/manager.   
Visitors are encouraged to stay away if sick. There is a staff health policy in place to ensure staff do not spread infections. The facility has signage to use for outbreaks and displays this information as needed. Residents are encouraged to have a flu vaccine. There are outbreak management supplies readily accessible for staff to set up bedrooms and toilets for isolation. There have been no outbreaks since the previous audit.

##### **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 co-ordinator provides a monthly report to the owner and staff. Meeting minutes sighted evidence infection control is discussed at the management and staff meetings.   
The facility also has access to infection prevention and control nurses from the DHB, an external aged care consultant, practice nurse, GP and Southern community laboratory. Internet access is available. There are pandemic supplies readily accessible to staff.

##### **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:**

D 19.2a: The organisation infection control policies and procedures are purchased from an external consultant. The policies are amended as required to meet the type of service provided. The policies and procedures have been reviewed June 2013 to reflect changes in best practice. A scabies management plan has been developed following an outbreak in August 2013. Staff sign to state they have read any new/reviewed policies for infection control.   
The manual includes (but not limited to) policies on hand hygiene, standard precautions, transmission based precautions, prevention and management of infections, antimicrobial usage, outbreak management, cleaning of equipment.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control coordinator is responsible for coordinating and providing education and training to staff. The IC coordinator has only been in the role for six months. He has attended DHB in services (incorporating IC) and completed the infection control course through Wairekia Polytechnic, Rotorua in 2005 and has maintained knowledge and skills in this area in previous employment roles. The infection control co-ordinator has been registered for an on-line infection control education course. Infection control education is provided annually for all staff (August 2013). Records of staff attendance is maintained. Infection control is included in the staff orientation programme. Infection control education occurs as appropriate with individual residents.

##### **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:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. The staff report a suspected infection to the RN/manager who develops a short term care plan for the management of the suspected infection. There are guidelines for the definition of infections included in surveillance that include urinary tract infection, respiratory tract infection, and skin and wound infections, skin and soft tissue infections (including cellulitis), eye and gastrointestinal infections.   
All infections are entered onto a monthly infection analysis form. A monthly report is completed by the infection control co-ordinator, which is distributed to relevant meetings. Trends and quality improvements are identified and monitored. Corrective actions are developed when needed and are implemented. Antibiotic use is monitored. Infection rates over the last year have been low. In May 2014 two residents had recurring urinary tract infections (UTI)s’. The RN/manager introduced daily yoghurts for both residents as researched. There has been a positive outcome with no UTIs over the last two months. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices.  
The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. Internal audits occur including laundry and cleaning, infection control and hand hygiene audits.

##### **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.)*