# Selwyn Care Limited - Selwyn Sunningdale

## Current Status: 3 July 2014

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

## General overview

Selwyn Sunningdale Village comprises a 33-bed residential care facility offering hospital-level care and rest home care. The village is owned by the Selwyn Foundation Group (SFG) who are a registered charitable trust.

On the day of the audit, there were 27 residents living at the premises (13 hospital and 14 rest home level residents).

The village manager is a registered nurse who has been in the role for nearly four years. She oversees three Selwyn Group villages (Selwyn Sunningdale and Selwyn Wilson Carlile in Hamilton and Selwyn St Andrew's in Cambridge). She is supported by a full time Care Lead who is a registered nurse. The Group Residential Care Manager from the SFG visits regularly. The village has corporate support from head office in Auckland.

The organisation has adopted a quality approach towards service delivery. The Selwyn Foundation quality and risk management systems are in place at Sunningdale and overseen by head office.

Improvements are required by the service around the documentation of cultural preferences, medicines management and restraint management.

## Audit Summary as at 3 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 3 July 2014

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

### Organisational Management as at 3 July 2014

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

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

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

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

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

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

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

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

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

## Audit Results as at 3 July 2014

### Consumer Rights

Information about services provided is available to residents and families prior to admission. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the facility. There are a suite of policies and associated procedures in place to support residents’ rights. Staff have a sound understanding of residents' rights and their ability to make choices. Care planning accommodates individual choices of residents' and/or their family. Residents, relatives, the physiotherapist and the general practitioner interviewed spoke positively about the care provided. Complaints processes are implemented and complaints and concerns are actively managed.

### Organisational Management

Selwyn Foundation Group operates villages in Whangarei, Auckland and Hamilton. The group is governed by a board of trustees. There is a strategic plan, which is available in the public domain. There is a business plan for the village, which is developed annually and aligns with the strategic direction. The business plan includes the quality plan. There are quality and risk management systems in place. The Selwyn Group monitors key quality and other performance indicators intensively and benchmark their facilities internally. Head office will inform the Village if their performance is inconsistent with that of other Selwyn Group providers. An external resident satisfaction survey has been completed. Regular resident and staff meetings are held. Key components of the quality and risk management system are discussed at the monthly staff meetings. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes to the health status of residents. The organisation has well implemented human resource processes. New staff are orientated to safe work practices and there is an in-service education programme in place that includes monetary support to caregivers to obtain ACE education. All staff are supported to attend first aid training. Managers have access to ongoing educational opportunities that exceed eight hours annually. There is a documented rationale for staffing which has been developed to meet national guidelines and acuity levels. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staff believe that the Village is a good employer and staff turnover is stable.

### Continuum of Service Delivery

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed six monthly following admission. Residents and/or family have input into the development of care plans. Communication with family is well documented.

Residents have an individualised care plan that reflects current needs. The documentation of cultural needs was not evidenced, this is an area requiring improvement. Care plans are reviewed six monthly and updated as needs change.

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

An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications and have completed competency assessments. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are no residents who are self-medicating. There is an improvement required around documenting indication for use of PRN (as required) medicines.

The service has transfer and discharge procedures. Staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. Food is cooked at an associated facility, the majority of residents and families interviewed expressed satisfaction with food services.

### Safe and Appropriate Environment

The building holds a current warrant of fitness. The main entrance door is kept electronically locked at all times. The door is able to be opened internally by pushing a button to exit. Residents were seen exiting the premises through these other doors and sitting outside in the sun. The facility is experiencing problems with its heating system overheating the building. The situation is being managed through opening windows. The central heating has been included in the capital expenditure request for this year and is noted as a high priority request. There is a waste management system in place. Cleaning services are monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff. Rooms are individualised. The grounds are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are spacious lounges and a dining area, there are adequate toilets and showers. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificates.

### Restraint Minimisation and Safe Practice

The service has policies and procedures that aim to actively minimise the use of restraint. There is a restraint co-ordinator who is a registered nurse. There are four residents that require restraint and one resident who is voluntarily using an enabler (all of these relate to the use of bed rails to prevent the residents from falling out of bed). Staff are trained in restraint minimisation and safe practice. Improvements to the management of restraint are required.

### Infection Prevention and Control

The infection prevention and control coordinator is a registered nurse. The service has infection prevention and control policies to guide practice. The infection prevention and control programme is monitored for effectiveness and linked to the quality risk management plan. Infection prevention and control education is provided annually for staff and practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. Surveillance and associated activities are appropriate for the size and complexity of the service.

# 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:** | Selwyn Care Limited |
| **Certificate name:** | Selwyn Care Limited - Selwyn Sunningdale |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Selwyn Sunningdale Village |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 3 July 2014 | **End date:** | 4 July 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 27 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12.5 | **Hours off site** | 8 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 12.5 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 25 | Total audit hours off site | 18 | Total audit hours | 43 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 13 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 28 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| 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 Thursday, 7 August 2014

## Executive Summary of Audit

**General Overview**

Selwyn Sunningdale Village comprises a 33-bed residential care facility offering hospital-level care and rest home care. The village is owned by the Selwyn Foundation Group (SFG) who are a registered charitable trust.

On the day of the audit, there were 27 residents living at the premises (13 hospital and 14 rest home level residents).

The village manager is a registered nurse who has been in the role for nearly four years. She oversees three Selwyn Group (SFG) villages (Selwyn Sunningdale and Selwyn Wilson Carlile in Hamilton and Selwyn St Andrew's in Cambridge). She is supported by a full time Care Lead who is a registered nurse. The Group Residential Care Manager from the SFG visits regularly. The village has corporate support from head office in Auckland.

The organisation has adopted a quality approach towards service delivery. The Selwyn Foundation quality and risk management systems are in place at Sunningdale and overseen by head office.

Improvements are required by the service around the documentation of cultural preferences, medicines management and restraint management.

**Outcome 1.1: Consumer Rights**

Information about services provided is available to residents and families prior to admission. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the facility. There are a suite of policies and associated procedures in place to support residents’ rights. Staff have a sound understanding of residents' rights and their ability to make choices. Care planning accommodates individual choices of residents' and/or their family. Residents, relatives, the physiotherapist and the general practitioner interviewed spoke positively about the care provided. Complaints processes are implemented and complaints and concerns are actively managed.

**Outcome 1.2: Organisational Management**

Selwyn Foundation Group operates villages in Whangarei, Auckland and Hamilton. The group is governed by a board of trustees. There is a strategic plan, which is available in the public domain. There is a business plan for the village, which is developed annually and aligns with the strategic direction. The business plan includes the quality plan. There are quality and risk management systems in place. The Selwyn Group monitors key quality and other performance indicators intensively and benchmark their facilities internally. Head office will inform the Village if their performance is inconsistent with that of other Selwyn Group providers. An external resident satisfaction survey has been completed. Regular resident and staff meetings are held. Key components of the quality and risk management system are discussed at the monthly staff meetings. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes to the health status of residents. The organisation has well implemented human resource processes. New staff are orientated to safe work practices and there is an in-service education programme in place that includes monetary support to caregivers to obtain ACE education. All staff are supported to attend first aid training. Managers have access to ongoing educational opportunities that exceed eight hours annually. There is a documented rationale for staffing which has been developed to meet national guidelines and acuity levels. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staff believe that the Village is a good employer and staff turnover is stable.

**Outcome 1.3: Continuum of Service Delivery**

Resident files reviewed include service coordination centre assessment forms. The facility information pack includes all relevant aspects of service, and this is provided to residents and/or family/whanau prior to entry. Care plans are developed in consultation with relevant people including residents and where appropriate family / whanau or Enduring Power of Attorney. An initial nursing assessment, including a variety of risk assessments are completed on admission and risk assessments are reviewed six monthly following admission. Residents and/or family have input into the development of care plans. Communication with family is well documented.

Residents have an individualised care plan that reflects current needs. The documentation of cultural needs was not evidenced; this is an area requiring improvement. Care plans are reviewed six monthly and updated as needs change.

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

An appropriate medicine management system is implemented. Policies and procedures detail service provider's responsibilities. Registered nurses administer medications and have completed competency assessments. Medication charts sighted evidence documentation of residents' allergies/sensitivities and three monthly medication reviews completed by general practitioners. There are no residents who are self-medicating. There is an improvement required around documenting indication for use of PRN (as required) medicines.

The service has transfer and discharge procedures. Staff interviewed are knowledgeable of their responsibility of safe exit or discharge to another facility or hospital. A dietitian is available to provide dietetic assessment for residents and arrange special authorities as required. Food is cooked at an associated facility, the majority of residents and families interviewed expressed satisfaction with food services.

**Outcome 1.4: Safe and Appropriate Environment**

The building holds a current warrant of fitness. The main entrance door is kept electronically locked at all times. The door is able to be opened internally by pushing a button to exit. Residents were seen exiting the premises through these other doors and sitting outside in the sun. The facility is experiencing problems with its heating system overheating the building. The situation is being managed through opening windows. The central heating has been included in the capital expenditure request for this year and is noted as a high priority request. There is a waste management system in place. Cleaning services are monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff. Rooms are individualised. The grounds are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. There are spacious lounges and a dining area, there are adequate toilets and showers. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificates.

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

The service has policies and procedures that aim to actively minimise the use of restraint. There is a restraint co-ordinator who is a registered nurse. There are four residents that require restraint and one resident who is voluntarily using an enabler (all of these relate to the use of bed rails to prevent the residents from falling out of bed). Staff are trained in restraint minimisation and safe practice. Improvements to the management of restraint are required.

**Outcome 3: Infection Prevention and Control**

The infection prevention and control coordinator is a registered nurse. The service has infection prevention and control policies to guide practice. The infection prevention and control programme is monitored for effectiveness and linked to the quality risk management plan. Infection prevention and control education is provided annually for staff and practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. Surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 46 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 3 | 1 | 0 | 0 |

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

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.5: Planning  | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Two residents that identify as Maori did not have documented evidence of cultural care planning. | Ensure that residents identifying as Maori have Maori care planning completed. | 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 | Eleven of twelve medication charts sampled did not show evidence that indications for use of PRNs were documented by the GP. | Ensure that all charted PRN medication has documented indication for use by the GP. | 30 |
| HDS(RMSP)S.2008 | Standard 2.2.2: Assessment | Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.2.1 | In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:(a) Any risks related to the use of restraint;(b) Any underlying causes for the relevant behaviour or condition if known;(c) Existing advance directives the consumer may have made;(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;(f) Maintaining culturally safe practice;(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);(h) Possible alternative intervention/strategies. | PA Low | The restraint/enabler assessment process was not fully completed for one of the five residents who was using an enabler.  | Ensure the assessment process is fully considered and the required consents and approvals are fully obtained prior to implementation. | 90 |
| HDS(RMSP)S.2008 | Standard 2.2.3: Safe Restraint Use | Services use restraint safely | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.3.5 | A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | The restraint register incorrectly identified the resident who was using an enabler as being restrained. | Ensure the information documented in the restraint register is accurate. | 90 |

## Continuous Improvement (CI) Report

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

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

## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Staff are educated on consumer rights legislation as part of their orientation and are provided with refresher education on an on-going basis (Last education session occurred May 2014. Caregivers are able to articulate how residents’ rights are upheld as part of daily life in the facility (confirmed in discussion with five of five caregivers)

The Selwyn Foundation Group (hereafter referred to as SF Group) has a suite of policies to guide staff on consumer rights. These include the resident rights and responsibilities policy, complaints management policies, and service delivery policies. Staff were observed during the day providing care and support to residents in a caring and respectful manner.

D1.1c: Staff comply with the Health and Disability Commissioner Act 1994.

D3.1a: Services being provided on the days of audit showed that staff provided resident-centered care.

##### 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:**

Information on the Code and other rights is provided prior to entry and on entry. Information is readily available in the facility. Staff explain the relevance of the Code on entry and as appropriate thereafter (e.g., if a consumer or their representative wish to make a complaint). Information about the Nationwide Health and Disability Advocacy Service is on display at the facility. An advocate visits residents periodically. Any consumer or their representative wishing to make a complaint is reminded of the availability of the Nationwide Advocacy Service.

D6.1& 2: The Code is used to inform residents of their rights

D16.1 b iii: All residents are given a copy of the Code on entry to the facility as part of the welcome pack of information (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four family (two rest home and two hospital)).

##### 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:**

Consumers are treated with respect (observed and confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four relatives (two rest home and two hospital). There is policies and practices in place to ensure residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. Staff receive refresher education on residents’ rights including privacy, the right to be free from abuse and neglect and the right to culturally safe care (last education session held 13 May 2014). All residents have their own rooms to maximise their privacy. There are privacy locks on communal toilet areas. Staff speak to residents respectfully and can articulate the actions they take to promote resident independence (confirmed in discussions with five of five caregivers). Staff take care to ensure residents’ belongings are stored safely. Services are responsive to the needs, values, and beliefs of each resident. Staff are required to note specific cultural, religious, social, and matters that are important to each resident on entry to the facility. This information is required to be updated as new information becomes known.

D3.1b: Staff promote the independence of residents and their quality of life.

D3.1d: Staff involve residents in decisions that affect their lives (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four relatives (two rest home and two hospital)).

D3.1f; Staff respect the rights of residents.

D3.1i; Residents are provided with a comfortable and safe environment to maximise their well being

D3.1j; End of life care is provided and this is usually in consultation with the local hospice

D4.1a: Services provided recognise the comfort, privacy and dignity of each resident.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The SF Group documents its commitment to working in line with the principles of the Treaty of Waitangi. There is a Maori health plan in place and there is policy to ensure the tikanga are respected. The SF Group has a designated cultural advisor who is available to all staff and residents. There is mandatory cultural awareness training for all staff (last provided May 2014). There is a defined process for consulting with local iwi.

There is a section in the assessment tool and care plan that includes cultural and spiritual needs (Link finding in Criterion 1.3 5.2). Planning is done in conjunction with the resident and with prior consent, their whanau. The service's philosophy of care results in each person's cultural needs being considered individually. The cultural advisor can be contacted as required. A list of Maori advisors and advocacy services is provided in the cultural manual.

There is on-going consultation as to the cultural appropriateness of the care provided (confirmed in discussions with five of five caregivers)

A3.1: Services are provided that respect residents who identify themselves as Maori. On the day of audit there were two residents who identified themselves as Maori.

A3.2: There is a Maori health plan and policy in place to guide staff to ensure they meet the specific needs of residents who identify as Maori.

##### 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:**

Residents' cultural and spiritual values and beliefs are required to be documented on entry and thereafter respected. Staff receive training on values and beliefs (last provided May 2014). Residents believe that their cultural values and beliefs are respected (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four family (two rest home and two hospital)).

D3.1g: The service provides a culturally appropriate service by having policies and procedures relevant to cultural safety. Training occurs annually around culturally safe care (last delivered May 2014).

D4.1c: Care plans reviewed include information on the residents' social, spiritual, cultural and recreational needs (with the exception identified in criterion 1.3.5.2)

##### 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:**

There is policy in place to ensure residents are not subjected to discrimination and exploitation. Staff training around the Code includes discussion about discrimination and discussions about appropriate boundaries when providing care to residents. Management encourage feedback from residents, their family and staff. Management are confident that any instances of discrimination would be brought to their attention by residents, their families or staff (confirmed in discussions with seven of seven residents (four rest home and three hospital), four of four families (two rest home and two hospital), five of five caregivers, and two of two managers (i.e., one care leader and one village manager)).

##### 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 service has policies and procedures and associated management systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. There is regular quality feedback both within the service and to the governing body. Services are monitored by the SFG. The village is visited regularly by the Selwyn Group residential care manager.

##### 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 service provides an environment which enables effective communication with residents. This includes full information at entry and open disclosure. Management contact relatives and discuss matters in an open manner consistent with the open disclosure policy. Residents are orientated to the service on admission. Informed consent processes are in place. Residents have access to interpreter services which includes access to the Blind Foundation and the Hearing Association. There are regular residents meetings. Staff have on-going education on how to communicate well with residents (last education provided May 2014).

A 13.1 & D13.2: Each resident or their nominated representative is provided with an admission agreement and a copy is stored onsite.

A 14.1: The Admission Agreement references exclusions from the service and is based on the Aged Residential Care Association Agreement template.

D 11.3: The information pack is easy to read and if needed the information can be read to residents.

D12.1 & D12.3a: Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D 12.4 & D12.5: Residents (and/or their representatives) informed in their agreement of the right to apply for a review of their means assessment.

D16.1b.ii: The residents and family are informed in the agreement prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Relatives are notified as soon as staff become aware that a resident’s health has changed significantly (confirmed in discussions with four of four relatives (two rest home and two hospital)).

D 16.5e, iii: On-call emergency services are available and the costs are met by Sunningdale.

##### 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:**

Written informed consents are gained as part of the signing of the Admission Agreement. Staff ask residents their preferences and they are able to make choices (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four family (two rest home and two hospital)). Advanced directives for resuscitation orders were appropriate for seven of seven clinical files sampled (three from the rest home and four from the hospital). Seven files have valid consents. Family involvement occurs with the consent of the resident. Other forms of written consent included, consent to share information, consent for treatment and consent for transportation. A review of seven files found all consents were present and signed by the resident or their representative (i.e., EPOA). EPOA documents are kept on the resident's file. Seven residents interviewed (four from the rest home and three from the hospital) confirm that they are given good information to be able to make informed choices. Five caregivers, two registered nurses and one care leader interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.

D13.1 There were six of seven admission agreements sighted and all six had been signed on the day of admission. One agreement has yet to be signed and a letter has been sent to one resident’s family. The village manager is expecting to receive the signed admission agreement shortly.

D3.1.d Discussion with four family (two from the rest home and two from the hospital) identified that the service actively involves them in decisions that affect their relative’s lives.

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. Informed consent in-service training for staff was held in February and May 2014. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with five caregivers, two registered nurses and one care leader identify that consents are sought in the delivery of personal cares and this is confirmed by seven residents interviewed (four rest home and three hospital).

Resuscitation policy is implemented and there are signed forms in all resident files reviewed. Resuscitation forms are reviewed annually.

D3.1.d: Discussion with four of four family/whanau identified that the service actively involves them in decisions that affect their relative’s lives.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

A range of information is available which identifies how and when to access advocacy services. Advocacy brochures are readily available and displayed. The residents’ rights and responsibility procedures and related documents includes access to advocacy service. Staff receive training (last provided May 2014). Caregivers are familiar with the concepts of advocacy and how to access services if needed (confirmed in discussions with five of five caregivers).

D4.1d: Staff involve residents and/or their representatives in discussions that affect residents (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four relatives (two rest home and two hospital)).

D4.1e: Staff acknowledge the significance of each resident’s family/whanau and their chosen representatives (confirmed in discussions with four of four relatives (two rest home and two hospital)).

##### 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:**

Residents are well supported to maintain links with their family and the community. Residents are encouraged to participate in community activities as they are able. Families are encouraged to be involved with the service and care. There is a policy of open visiting. Families were visiting residents throughout the audit. Residents have access to visitors of their choice (confirmed in discussions with seven of seven residents (i.e., four rest home and three hospital)).

D3.1h: Staff encourage the involvement of family (confirmed in discussion with four of four relatives (two rest home and two hospital)).

##### 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:**

There is a documented complaints policy and associated procedure that compiles with Right 10 of the Code of Health and Disability Services Consumers’ Rights. The complaints process is easily accessible to residents and family members (observed and confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four family (two rest home and two hospital)). Complaints are logged in a complaints register. The register is up-to-date and includes all complaints, dates, and actions taken. Complaints are managed locally with head office oversight to ensure all complaints are managed appropriately. All allegations are actively investigated. Management report all complaints to the SFG through the weekly reporting channels. Staff are aware of the complaints policy and can correctly articulate their responsibilities (confirmed in discussion with five of five caregivers). Staff have ongoing education on consumer complaints management (last provided May 2014). Copies of complaints for 2014 year to date were sighted (both hard copy complaint and entries on the complaint register). There have been complaints about the food and the heating. Justified complaints have been actioned. The DHB raised one matter of concern with the facility on 7 May 2013 and this matter was addressed and is now closed.

##### 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:**

Sunningdale provides care for up to 33 residents which includes 24 hospital level residents and up to 9 rest home residents. At the time of the audit, there were 13 hospital and 14 rest home level residents living at the premises (of which one rest home resident was in hospital on the day of audit).

Sunningdale is owned by Selwyn Care Limited who is wholly owned by the Selwyn Foundation Group, who is a registered charitable trust. The SF Group is governed by a Board of Trustees. Head office is located in Auckland. SFG has a 5 year strategic plan covering 2013 to 2017, which is available in the public domain on the internet. The strategic plan identifies the overall mission which is to deliver quality services that are responsive to the ageing person and their family, ensuring that our charitable outreach supports those who are vulnerable or in need. There is a Group annual business plan and a linked local business plan for Sunningdale. The business plan is monitored formally by the General Manager, Village and Marketing, SFG. The village business plan incorporates the quality plan.

The village is managed by a full-time care lead (i.e., a clinical co-ordinator) who is a registered nurse. The care lead is supported by the village manager who is a registered nurse that has been in the role for nearly four years. Both managers have the authority, accountability, and responsibility for the provision of care (confirmed in review of their position descriptions). The village manager manages two other villages, which are Selwyn Wilson Carlile Village (Hamilton East) and Selwyn St Andrews Village, Cambridge. SFG is in the process of recruiting and appointing an assistant village manager, who will be based at Wilson Carlile Village and will work across both Hamilton Villages, which are located close to one another. The managers are supported by the Group Residential Care Manager who visits frequently and the executive team based in Auckland.

There are robust quality and risk management systems in place, which are standardised and implemented across all villages. The system is monitored closely by head office. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001.

The quality monitoring programme includes an internal audit schedule which is designed to monitor contractual and standards compliance. and the quality of service delivery in the facility. Identified compliance issues results in a corrective action plan being generated and intensively monitored by head office staff.

A18.1; There are sound financial management systems in place, coordinated from head office.

A27.1; There is comprehensive insurance covering the business throughout the term of the Agreement (confirmed by email with the CFO). The village has business cover for business interruption, commercial motor vehicles, corporate travel, management liability, building material damage, and contract works. The policy period is 1 May 2014 to 1 August 2015.

A30.1; SFG does not assign service delivery to another provider (confirmed in discussion with the village manager).

D5.1; D5.2; D5.3; There is a range of policies and procedure in place to guide the provision of services.

D17.3di (rest home), D17.4b (hospital), there is a least one registered nurse on duty at all times.

D 17.5: The care lead (i.e., clinical manager) is a registered nurse with a current practising certificate and has completed at least eight hours of professional development in the last 12 months. She is employed to work full-time. The care lead has been employed at Sunningdale since September 2010. The care lead will report to the assistant village manager (position current vacant) who in turn will report to the village manager and the Group Residential Care Manager. The facility manager is experienced in management and is a registered nurse with a current practising certificate. The facility manager has maintained at least eight hours annually of professional development activities related to managing a hospital. The facility manager has been in the role for nearly four years and has an MBA. Both are supported by a team of registered nurses and they have access to support from the leadership team and corporate services.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

During a temporary absence of the care lead the service would be managed by the assistant village manager with head office support. If the absence was longer than a few days head office would provide onsite support.

D3.1: Services are provided in an efficient and effective manner consistent (confirmed by observation and in discussions with seven of seven residents (four rest home and three hospital), four of four relatives (two rest home and two hospital)).

D19.1a: Management are aware of the need to maximise the safety of residents by effective risk management (confirmed in discussions with the care lead and the village manager).

##### 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:**

SFG has committed to pursuing the business excellence quality model. The quality and risk management system is outlined in the annual business plan. The plan is understood and implemented by management and staff, and monitored by head office. There are a range of policies and procedures in place that are aligned with current good practice and service delivery, meet the requirements of legislation. Policies are held electronically and managed by head office. Policies are reviewed every three years or if there is a change in legislation or practice necessitating review. The review period is documented in the document control policy. Documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Key components of service delivery are explicitly linked to the quality management system (e.g., consumer complaints management, consumer satisfaction reporting, the internal auditing system, the incident/accident system, the infection prevention and control system, and the health and safety system). Caregivers and registered nurses are aware of the need to document incidents and accidents (confirmed in discussions with five of five caregivers and three registered nurses).

There is a system to collect quality improvement data each month and head office have a dedicated business analyst who supports all villages. Data are collected, analysed, and evaluated and the results communicated to each village each month and, where appropriate, staff and consumers. Sunningdale continues to collect data to support the implementation of corrective action plans. Monthly data is collected for incidents and accidents, infection control and hazards. The data are collated on site and reported to head office who perform trend analysis and benchmark results between villages. Data collected includes but is not limited to, falls, infections, chronic infections, unexpected weight loss, incidents that are not falls, drug errors, unwanted events, staff incidents, pressure areas, restraints and enablers and compliments and complaints. Data, analysis and trends are discussed at facility meetings. Trend charts are displayed in the staff room. Staff have been actively working on reducing the falls rate for residents. Since 2011 they have reduced the number of falls from 134 to 78 in 2013. Year to date until June there have been 22 falls. Strategies implemented have included raising staff awareness, increasing the use of alarm mats, implementing a traffic light system for risk, educating staff, appointing a physiotherapist and running a daily exercise programme for residents. There is an internal auditing annual schedule in place, which is overseen by head office. There is a process to measure achievement against the quality and risk management plan, which is through the management structure and a weekly reporting system that includes weekly review by the CEO of SFG. Quality and risk performance is reported at the monthly staff meetings and is also reported to the organisation's management team. There are resident and family meetings held on a two monthly basis and minutes are maintained. Annual resident and relative surveys are completed by an external agency. The last survey included all residents and families living in the facility in November 2013. There were 15 respondents to the survey which included 5 residents. The results of the survey are not easy to interpret (confirmed in discussions with staff). Results are benchmarked against other facilities in New Zealand and Australia (e.g., the facility was ranked higher than 73 per cent of the other facilities in the sample and the response rate on the temperature of the resident’s room was identified as being not applicable).

A4.1: There are a range of policies in place.

D1.1 & D1.2; Managers are aware of the need to comply with relevant legislation (discussed with three managers who included the Care Lead, the Village Manager and the Group Residential Care Manager).

D5.4: All policies as listed in the Agreement exist to guide staff

D10.1: There is policy in place to guide staff in the expected and unexpected death of a resident

D17.7a,b,e; RNs are required to demonstrate competencies prior to performing tasks, procedures or treatments and there are policies in place to guide staff in managing clinical and non-clinical emergencies.

D19.1, 2, 3, 4 &.5: There are established quality and risk management systems in place, which include a quality assurance programme and a quality improvement programme.

##### 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:**

D19.3a.vi: Sunningdale has a system in place to manage incidents, accidents and hazards. All adverse events are managed and then documented. Both the care lead and the village manager review each adverse event. The care lead would review these events every working day. Serious events would be discussed with the village manager by telephone. Events are collated at village level, reported to head office, benchmarked between facilities and monitored intensively. There is a hazard register in place on display in the manager’s office. Staff are provided with on-going education about reporting adverse events (last education provided May 2014).

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

D19.3c: The key risks of theft/burglary, fire, accidents & incidents, chemical incidents and disposal of waste are noted.

The service understands their requirements in regard to essential notification reporting. The process in place is that adverse events are managed at the time, then documented and reported to head office and reported to the appropriate agency (e.g., DHB, or Ministry of Business, Innovation and Employment).

There is an open disclosure policy in place and family members interviewed stated they are informed of changes in health status.

##### 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:**

Human resource policies are in place for recruitment, appointment, orientation, performance management and exit management. There is a process of reference checking, checking of qualifications, Police record checking, and ensuring health practitioners maintain current practising certificates (confirmed in review of nine of nine staff records, which included five registered nurses, three caregivers and the clinical lead and in discussions with five of five caregivers). Staff employment records are well maintained. There is an education plan in place for care staff. The organisation conducts both mandatory training and site specific training. In-service education for caregivers is mandatory and they are paid to attend. Caregivers are encouraged to complete ACE training qualifications. There is a competency based pay scale in place for caregivers. All staff are encouraged to attend first aid training. Attendance at training is recorded in an Excel spreadsheet and monitored by management. Registered nurse competencies are assessed for a broad range of technical skills. Medicines management competencies are assessed. Staff appreciate the support they receive to access education.

D17.6: All newly engaged staff receive an orientation (confirmed in review of nine of nine employment records and in discussions with five of five caregivers).

D17.7: Registered staff are required to demonstrate competencies in medicine management, wound management and other technical skills needed by residents.

 D17.8.There is an on-going programme of staff development. SFG are committed to providing educational opportunities for staff and staff turnover is low.

##### 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:**

The service has a staffing policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The staffing rational is documented using an approved formula for calculating required hours for acuity level and staffing levels and rosters are adjusted accordingly. Budgeted hours are set. The manager advised that staff turnover is stable. Caregivers who work on all shifts and with both rest home and hospital level residents stated that the staffing levels are okay. There is registered nurse cover across the facility over 24 hours.

Seven residents (four rest home and three hospital) confirm that staffing levels are good.

The service contracts with allied health professionals on an as required basis which includes a physiotherapist once a week.

D17.1; Management are aware that they must provide sufficient staff to meet the health and personal needs of residents.

D17.3 (Rest Home) and D17.4 (Hospital). Management are aware of the need to ensure the facility has the correct management structure in place and that there is a registered nurse (RN) on duty at all times. Both the care lead and the village manager are registered nurses.

##### 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:**

Guidelines are documented for the management of health records. Heath records are both paper based and demographic information is held electronically. Required records which are appropriate to the service are maintained. Records are secure and maintained in line with the Privacy Act. Computers are password protected. All entries in the paper based records were accurate and up-to-date. A register of past and present residents is accessible. All residents have a hard copy file that includes care planning information and these are kept in the nurse's station. All clinical records pertaining to individual residents are integrated. The clinical records policy identifies the requirements of maintaining both hard copy and electronic records in line with the Privacy Act and Health Records Standards.

A15.1: Business and consumer records are held in hard and soft copy. Sunningdale uses an electronic patient information management system more for business and financial management purposes. The majority of clinical records are paper-based. Archived records are stored onsite.

D7.1: RNs and caregivers maintain a written record of progress for each shift. Records are legible, dated, and signed by the relevant staff member including their designation

D8.1: The GP records their findings following consultation with each resident. The GP entries are legible, dated and signed by the GP.

D22: Performance monitoring reporting to the DHB occurs each quarter and this is processed by head office.

##### 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:**

All potential residents have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service prior to entry. 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 are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The admission policy describes the declined entry to services process. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency. The village manager reports that there has been no reason to decline a potential resident.

##### 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:**

D16.2, 3, and 4: The seven resident files reviewed (three from the rest home and four from the hospital) identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Caregivers’ report that the care plans are easy to follow (confirmed in discussions with five of five caregivers). Six of seven care plans evidenced evaluations completed at least six monthly. One resident has been at the service less than six months. Activity assessments and the activities care plans have been completed by the activities coordinator. Seven residents interviewed (three from the hospital and four from the rest home) interviewed stated that they and/or their family were involved in planning their care plan and at evaluation. Resident files included family contact records, which were completed in all resident files sampled.

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

A range of assessment tools where completed in resident files on admission and completed at least six monthly including (but not limited to); a) falls risk assessment, b) pressure area risk assessment, c) continence assessment and d) pain assessment. Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Seven files reviewed identified integration of allied health and a team approach is evident.

Tracer Methodology hospital:

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

Tracer Methodology rest home:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks (confirmed by observation and in discussions with three of three registered nurses and five of five caregivers). Personal needs information is gathered during admission (confirmed in discussions with seven of seven residents (four rest home and three hospital) and four of four family (two rest home and two hospital)). The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes (# link 1.3.5.2). Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission. Pain assessment was evidenced completed with on-going monitoring recorded for residents requiring administration of controlled medication as part of prescribed pain management plan. Four family (two from the rest home and two from the hospital) and seven residents interviewed (three from the hospital and four from the rest home) interviewed are very satisfied with the support provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A review of seven resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Five of seven are current and include interventions relating to all identified areas of need. Two residents that identify as Maori did not have documented evidence of cultural care planning. This is an area requiring improvement. There is evidence of six monthly review, which is signed by a registered nurse.

The care plan is completed within three weeks of admission by the registered nurses providing a holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist.

Caregivers find the plans easy to read and understand (confirmed in discussions with five of five caregivers).

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

All seven resident files reviewed identified that family were involved. Family contact sheets located at the front of residents' files demonstrated communication with family/EPOA.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A review of seven resident files identifies the use of short term and long term care plans. These reflect variances in resident health status. Five of seven are current and include interventions relating to all identified areas of need.

**Finding:**

Two residents that identify as Maori did not have documented evidence of cultural care planning.

**Corrective Action:**

Ensure that residents identifying as Maori have Maori care planning completed.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Seven resident files were reviewed (three from the rest home and four from the hospital). All identified that an initial nursing assessment and care plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes. Six of seven care plans evidenced evaluations completed at least six monthly. One resident has been at the service less than six months. Activity assessments and the activities care plans have been completed by the activities coordinator. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, care leader and two registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical review for rest home residents and monthly for hospital residents. The care leader is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded by caregivers in the progress notes daily for all residents and RNs write at least weekly or when there are any medical or personal care changes (evidenced in all seven residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The five caregivers, two registered nurses and the care leader interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, slippery sams, hoists, electric beds, wheelchairs, sit on weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Seven residents interviewed (three from the hospital and four from the rest home) and four family (two from the rest home and two from the hospital) interviewed were complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans and evaluations are in place for two residents with wounds. One hospital resident with a skin tear and one rest home resident with skin tears. There are no pressure areas. Both wounds have been reviewed within the stated timeframe. There is evidence of GP input into both residents’ wounds.

The registered nurses interviewed (three of three) described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided in October 2013.

Residents and relatives interviewed were able to confirm that the care was appropriate (confirmed in discussions with seven of seven residents and four of four family members.

Caregivers and the registered nurses report they have sufficient supplies and equipment to provide care (confirmed by observation and in discussions with three of three registered nurses and five of five caregivers).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an activities coordinator at the service who is responsible for the planning and delivery of the activities programme was interviewed. The coordinator works Monday-Friday 10am -3pm and has been in the position for five years. The activities coordinator is currently completing the diversional therapy training and meets regularly with other diversional therapists. The activities coordinator discusses the programme with the village manager. The programme is combined for rest home and hospital residents. Activities are provided in the main lounge, dining room, gardens (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities including exercises, floor games, boards games and quizzes. The programme is developed monthly and weekly activities are displayed on the notice board. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events.

The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this is added into the 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 monthly and regular progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs including exercises, crafts, quizzes, bowls tournaments, visit to the chocolate factory, pet visits, café and lunch outings and music. Participation in all activities is voluntary. There is one volunteer that helps out with activities twice weekly. The activities coordinator facilitates the monthly residents meetings. Activities are discussed with residents at each meeting to obtain feedback on the programme and encourage resident input. Resident’s choice time is included in the activities programme.

The service has a van for transportation that is shared with an associated facility. Residents have outings twice weekly. Residents interviewed described, going shopping, lunches, coffee outings, visiting areas of interest. Seven residents interviewed (three from the hospital and four from the rest home) and four family (two from the rest home and two from the hospital) interviewed were complimentary about the activities programme.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is at least a three monthly review by medical practitioner (confirmed in review of the clinical records and in discussions with seven residents (three from the hospital and four from the rest home) and four family (two from the rest home and two from the hospital)).

D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in six of seven care plans sampled and confirmed in discussions with three of three registered nurses and the Care Lead. One resident has been at the service less than six months. There are short term care plans (STCP) to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. One STCP evidenced management of congestive heart failure with fluid, weight, oedema and shortness of breath monitoring. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included; infections, weight loss, behaviours and wounds. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by a registered nurse within three weeks of admission

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The care leader and registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, mental health and stroke club.

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

D 20.1; Discussions with the registered nurse and care leader identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, gerontology nurse from the Selwyn group, mental health community nurse, occupational therapist and physiotherapist.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities (sighted in preparation for transfer of one resident). Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in the locked treatment room in the hospital and rest home (combined). Controlled drugs are stored in a locked safe in the treatment room and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred. The service uses four weekly robotic sachet medication management system and medico blister packs for PRN medication. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. All 12 administration sheets sampled correlate with prescribed instructions. Only 1 of 12 medication charts had PRN medications charted with indication for use. This is an area requiring improvement. There is one medication folder which includes a list of specimen signatures.

Medication profiles are legible, up-to-date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name.

Education on medication management occurred in October 2013. Registered nurses administer medicines and senior caregivers check controlled medications if required (confirmed in discussions with the Care Lead and five of five caregivers). All staff who administer medicines have been assessed as competent. One registered nurse was observed administering medications safely, checking the medication with the GP prescribed medication chart and signing for the medication when the resident had been observed taking the medication. There are no residents currently self-administrating medications. Three eye drops in use were dated on opening. Medication fridge temperatures were sighted as checked daily.

 D16.5.e.i.2; Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

##### 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:**

Medication policies align with accepted guidelines. Medications are stored in a locked trolley in the locked treatment room in the hospital and rest home (combined). Controlled drugs are stored in a locked safe in the treatment room and two medication competent persons must sign controlled drugs out. Weekly stocktakes have occurred. The service uses four weekly robotic sachet medication management system and medico blister packs for PRN medication. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication signing sheet. All 12 administration sheets sampled correlate with prescribed instructions. 1 of 12 medication charts had PRN medications charted with indication for use.

**Finding:**

Eleven of twelve medication charts sampled did not show evidence that indications for use of PRNs were documented by the GP.

**Corrective Action:**

Ensure that all charted PRN medication has documented indication for use by the GP.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a kitchen that is for serving of meals and breakfast preparation only. All meals are cooked at Selwyn Wilson Carlile Village which is the neighbouring facility and have been for the last two years. Food is collected and delivered to the service in a dedicated food van that is fitted with a dedicated hot box for the transportation of food. There are two kitchen assistants that work on opposite days. The kitchen assistant works 9.30 am to 6.30 pm. One kitchen assistant (with a background in kitchen work) has only been at the service for one month and is scheduled to complete the food safety training. The other kitchen assistant has completed food safety training. Caregivers have completed food safety training in October 2013. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in July 2012 and is due for review in July 2014. When the food arrives it is put directly into the bain marie from where the food is served to residents. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. There is one fridge and temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily for lunch and tea. The main meal of the day is served at tea time.

Utensils such as lipped plates, modified cutlery and sipper cups are available and sighted in use.

All food in the fridge is labelled or dated and stored correctly.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes (all residents’ food requirements are sent to the associated facility). This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the associated facilities kitchen as reported by the kitchen assistant interviewed. Special diets are noted on a likes and dislikes form which is also kept in a folder in the services kitchen. Special diets being catered for include pureed diets, soft diets, and diabetic diets. Weights are recorded weekly/monthly as directed by the registered nurses. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. There are snacks available such as fruit, cheese and crackers, baking and sandwiches. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

The majority of residents and relatives confirmed that the food is generally pretty good and appreciated that not everyone is going to be happy with the food all of the time. One resident felt that there was room for improvement in the cooking and that potatoes should be mashed or at least well-cooked so that he could eat them. This concern was discussed with management who will address his concern. Satisfaction with the food service was confirmed in discussions with seven residents (three from the hospital and four from the rest home) and four family (two from the rest home and two from the hospital)).

##### 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:**

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboard away from resident’s communal areas. Staff receive on-going training on health and safety and the management of resident continence (last provided October 2013)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 1 December 2014. Electrical equipment was last checked August 2014. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and garden areas are extensive and attractive. The garden/decking area has furniture and covered in seating areas provide shade. There is wheelchair access to all areas. There is a designated smoking area outside. Hoists are serviced annually and this last occurred in May 2014. Equipment was last calibrated in May 2014.

ARC D15.3: The following equipment is available, electric beds, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids, sensor mats.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are communal toilets and showers close to bedrooms. Toilets are located close to dining rooms and lounges for residents' use. A visitor’s toilet is available. All rooms have hand basins. Four resident’s rooms have a full ensuite. Water temperatures are tested monthly by the maintenance person and records show they are within safe limits as sighted. Residents, families and caregivers report adequate numbers of toilets and showers in each area.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Observation on day of audit demonstrated walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with caregivers. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists safely.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a main lounge, a smaller lounge and a sun room. There is a large dining room that has recently been renovated. The lounges and dining room are accessible and accommodate the equipment required for the residents. There is also a large hall that is used for larger functions and is used by community groups such as RSA and hospice for educational days and community functions. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All laundry is completed on site by dedicated laundry staff. Chemicals are stored in a locked room away for resident’s communal areas. All chemicals are labelled with manufacturer’s labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean and free from stains. Carpets are commercially cleaned quarterly. All bedrooms, hallways and communal areas were clean and tidy in appearance. A cleaning audit occurred in February 2014 attaining 75 per cent. There was documented evidence that carpet cleaning and plumbing issues have been addressed as identified as corrective actions in the audit. A laundry audit completed in February 2014 achieved 100 per cent compliance.

##### 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 is a comprehensive health and safety manual, civil defence manual and emergency procedures manual in place to guide staff. Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations, which includes fire safety and emergency procedures. Fire drills are held six monthly and fire and emergency training was provided to staff at the same time. The last fire drill occurred on 11 March 2014 and was attended by 17 staff. There is a New Zealand Fire Service approved evacuation scheme with a covering letter dated 27 October 2000, which remains current. The facility is powered by electricity and gas. There is an alternative energy supply in the event of the main supplies failing. The facility also has a gas BBQ, torches, and extra emergency ‘silver’ blankets. There is some food on site and more food is stored at the neighbouring site to be used in an emergency. Emergency water is available on site in boxed containers. The facility has emergency lighting that lasts for four hours.

There is an appropriate 'call system' available to summon assistance when required. Residents have access to a call bell in their rooms and in communal areas. The system is monitored from an electronic box in the nurses’ station. The internal audit programme monitors call bells every two months (last internal audit was done June 2014).

D15.3e: There are procedures in place to ensure the safety and security of the residents at night. The security arrangements in place include locked doors and closed windows once dark and a security check is done at the midnight handover of caregivers.

D19.6: Sunningdale has a critical incident plan (i.e., a major incident and health emergency plan) that covers how services are provided in a civil defence or other emergencies. There is a separate pandemic plan. The plans are consistent with the national civil defence emergency plan and consistent with the DHB’s plan. The SFG is working closely with ADHB to ensure consistency of emergency planning. Sunningdale holds adequate pandemic and outbreak supplies onsite and a civil defence emergency kit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The facility has two heating systems and is experiencing problems with overheating and achieving a stable temperature throughout the building. Heat is circulated throughout the facility via vents in the floor including in each residents room. In addition there are two heat pumps located in the main lounge and dining room. One of the heating systems has recently been upgraded and the facility is working through maintaining adequate temperatures throughout the facility with the external contractor. The heating system is also included in the Capital expenses and is identified as a high priority request. Residents and staff have complained about over heating problems. Rooms are ventilated by opening windows and each room has natural light. Windows were open on the day of audit to let excess heat escape. Facility temperatures are being monitored to maintain a suitable temperature throughout the facility.

##### 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 are policies, procedures and forms included in the service delivery manual which advise staff about restraint minimisation. The policies are comprehensive, included definitions, processes and use of enablers. The Restraint Minimisation policy specifies that all enablers are voluntary. There is one resident using an enabler (bed rail) and four residents using restraints (bed rails). The documentation for each of these five residents was reviewed. There is a restraint co-ordinator. All staff receive training in restraint minimisation at orientation and as part of the in-service training programme (last restraint training October 2013). The previous restraint co-ordinator who is a registered nurse was interviewed as the current restraint coordinator (also a registered nurse) was on night shift and off duty on the day of audit. The previous restraint coordinator ceased acting in the position in February 2014.She was able to describe clearly the minimisation strategies used and processes for a resident with an enabler.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The responsibility for restraint process and approval is defined in the restraint minimisation procedure (i.e., policy). Responsibility is delegated to the restraint coordinator who is a registered nurse. The restraint coordinator has clear lines of accountability for restraint use and has a specific job description for the role. They must report to the facility manager (who is now the onsite Care Lead).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is an assessment process in place which is as follows: a registered nurse will commence the assessment and begin to complete the required restraint/enabler assessment and consent form. The RN will consult with the resident or their next of kin/family who is also required to sign the same form. The resident is reviewed by the GP who also signs the same form. The four residents with restraints in place were assessed and their forms were signed correctly. The resident using the enabler had signed her own form but the form was not signed by a GP (Link finding below in 2.2.2.1). Staff did not realise until the day of audit that the resident was using an enabler and not restraint. Staff reported that the GP is not asked to countersign the use of enablers as enablers are voluntary. Current policy however states that enablers must be treated the same as restraint and the restraint/enabler assessment and consent form confirms the approach specified in the restraint minimisation procedure. It is clear that a GP should have countersigned the use of the enabler.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The restraint policy requires that staff assess each resident prior to implementing restraint and complete the required documentation, which is the restraint/enabler assessment and consent form. The restraint/enabler assessment and consent form is required to be signed by a doctor and the resident or their representative.

**Finding:**

The restraint/enabler assessment process was not fully completed for one of the five residents who was using an enabler.

**Corrective Action:**

Ensure the assessment process is fully considered and the required consents and approvals are fully obtained prior to implementation.

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

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

Services use restraint safely

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

**Attainment and Risk:** PA Low

**Evidence:**

Restraint and enabler usage is documented in the resident’s plan of care and each episode of restraint or the application of an enabler is documented on a monitoring form. The restraint/enabler monitoring form is held in each resident’s room and is completed by caregivers when the restraint or enabler is applied and then removed.

A record of all residents using restraints and enablers is held in an electronic restraint register. The restraint register on the day of audit was not correct in that it incorrectly referred to the resident using the bed rail enabler as being restrained (refer finding 2.2.3.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The restraint coordinator and the managers manage the electronic restraint register and information from the register is reported to head office constantly.

**Finding:**

The restraint register incorrectly identified the resident who was using an enabler as being restrained.

**Corrective Action:**

Ensure the information documented in the restraint register is accurate.

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The use of restraints and the enabler are ongoing in the facility. Bed rails are used each night for these five residents. Each episode of restraint is evaluated by the staff member removing the restraint and comments are recorded on the monitoring form. The restraint coordinator is required to evaluate restraints and enablers monthly or more frequently as required. The evaluation occurs monthly as the bed rails have been in use for some time. The restraint coordinator or a registered nurse completes the restraint/enabler individual review form, which evaluates a range of factors. The use of the restraint or enablers are further considered by the resident’s GP every three months and the registered nurse and the GP and if appropriate the resident or their representative at the six monthly review of care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

Not sure here

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

SFG conduct comprehensive reviews through the internal reporting requirements and the internal audit programme. The restraint coordinator is required to conduct an internal audit every three months and enter the results of the audit on a spreadsheet which informs head office. The last internal audit was conducted on 19 May 2014. An error was detected and corrected. However the internal audit system in place failed to identify and correct the above discrepancies. Head office monitor and benchmark restraint and enabler usage between Selwyn facilities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

Not sure

**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 role of the infection prevention and control (IC) coordinator is held by one of the registered nurses who has been at the service for two years and held the IC coordinators position for one year. The IC coordinator currently works night shift. The IC has considerable aged care experience. The IC coordinator can access external specialist advice from GP's, laboratories and WDHB IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the Selwyn group’s clinical team and external expertise when required. IC is a standing agenda item at the monthly staff meetings (including quality) minutes viewed. Staff are informed about IC practises and reporting. They can contact the IC coordinator 24 hours a day, 7 days a week if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register.

There is a job description for the IC coordinator including the role and responsibilities of the position. IC is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The registered nurse is the IC coordinator. IC matters are taken to all staff and quality meetings (minutes reviewed). The IC coordinator can access external WDHB, IC nurse specialist, laboratories, and GP's specialist advice when required. The Selwyn group has the main responsible for reviewing the IC programme annually with input from the IC coordinator. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education. Access to specialists from the WDHB, laboratories and GP’s is available for additional training support. The IC coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has infection control policies and an infection control manual, which reflect current practise. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme is reviewed annually by the Selwyn group who can access external specialist advice to do this.

D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections

##### 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 IC coordinator is the registered nurse who has undertaken specialist IC training. The IC coordinator has completed an IC course and has recently attended a study day on infection control at WDHB. The IC coordinator has attended two IC meetings with the Selwyn group. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs (last provided October 2013). Three staff members attended education on an infection control for an outbreak in March 2014. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.

The IC coordinator collates the information which is entered onto the online infection register by the care leader. The Selwyn group produces monthly data which is then analysed by the IC coordinator. The analysis is reported to the monthly staff and quality meetings (minutes viewed). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. The service has documented evidence of a gastroenteritis outbreak in March 2014 that was appropriately managed and analysed with WDHB notification.

Internal audit of infection control is included in the annual programme and occurs yearly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting.

##### 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.)*