

# CHT Healthcare Trust - Halldene Rest Home

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Current Status: 19 August 2014

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

## General overview

Halldene provides rest home and hospital level care for up to 37 residents. The service intends to use five beds that are currently for rest home only use for rest home or hospital level use. On the day of audit there were six rest home residents and 31 hospital level residents.

This provisional audit was conducted to assess the preparedness of new owners for the facility and included an interview with the new area manager, review of the transition plan and interviews with the current facility manager, clinical auditor and care staff. The new owners, Christian Healthcare Trust (CHT), have 10 other facilities across the Auckland area. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures.

The service implements a quality and risk management programme identifying quality improvements through a variety of activities. The service is currently managed by an experienced facility manager who has been in the role for seven years. The manager is supported by a clinical auditor (registered nurse) who provides clinical oversight and management. There are registered nurses on duty at all times. The service continues to provide care to residents based on the current service's mission and philosophy of care. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around updating hazard registers, secure storage of resident information, development of activities care plans, secure storage of chemicals, service and calibration of medical equipment, and privacy locks on communal bathrooms.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	CHT Healthcare Trust		
<b>Certificate name:</b>	CHT Healthcare Trust - Halldene Rest Home		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Provisional Audit		
<b>Premises audited:</b>	Halldene Rest Home		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 19 August 2014	<b>End date:</b> 20 August 2014	
<b>Proposed changes to current services (if any):</b>	The service intends to use five beds that are currently for rest home only use for rest home or hospital level use.		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	37		

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	12	Total audit hours	36
Number of residents interviewed	9	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	7	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	15	Total number of staff (headcount)	31	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXX, 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 Friday, 29 August 2014

## Executive Summary of Audit

### General Overview

Haldene provides rest home and hospital level care for up to 37 residents. The service intends to use five beds that are currently for rest home only use for rest home or hospital level use. On the day of audit there were six rest home residents and 31 hospital level residents. This provisional audit was conducted to assess the preparedness of new owners for the facility and included an interview with the new area manager, review of the transition plan and interviews with the current facility manager, clinical auditor and care staff. The new owners, CHT, have 10 other facilities across the Auckland area. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures. The service implements a quality and risk management programme identifying quality improvements through a variety of activities. The service is currently managed by an experienced facility manager who has been in the role for seven years. The manager is supported by a clinical auditor (registered nurse) who provides clinical oversight and management. There are registered nurses on duty at all times. The service continues to provide care to residents based on the current service's mission and philosophy of care. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around updating hazard registers, secure storage of resident information, development of activities care plans, secure storage of chemicals, service and calibration of medical equipment, and privacy locks on communal bathrooms.

### Outcome 1.1: Consumer Rights

Haldene Residential Care provides new residents and their family with an information package that includes information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code, advocacy, the complaints procedure, cultural support and privacy. This is discussed on admission. Staff attend in-service training that addresses these subjects. The complaints management procedure meets the requirements of Right 10 of the Code. Resident's values and beliefs are discussed during the initial assessment process following admission and are documented in resident files. Residents have the opportunity to participate in residents' meetings. There is a weekly church service held at the facility and community groups provide entertainment. Family members are welcome at any time and are invited to celebratory events including birthdays, the weekly happy hour, carol singing and entertainment. The resident/relative satisfaction survey confirms that residents and their family are satisfied that their rights, privacy, values and beliefs are respected. This was also verified in discussion with relatives and residents. Relatives state that they are well informed about any incidents or changes to the resident's care and state that they are very happy with the care and support given to residents.

### **Outcome 1.2: Organisational Management**

The new owners of Halldene are experienced providers of aged care services. CHT was formed in 1962 and is a charitable trust. The trust board is supported by a chief executive and a finance manager. The organisation has a transition plan in place to facilitate the smooth transition between owners with the least disruption of services for staff and residents. The facility will be overseen by an area manager with implementation of CHT policies and procedures to be rolled out. Halldene is currently managed by a facility manager who has been in the position for four years. She is supported by a clinical auditor and five registered nurses who have current practising certificates. The business plan is approved by the current owners of the facility and addresses 10 key objectives. The philosophy and mission statement is described in the residents' information pack and in the information provided during orientation of new staff. The facility's quality philosophy is expressed in a range of policy documents. Policy documents are prepared and reviewed by an independent aged care advisor from the Care Association of New Zealand (CANZ). A range of data is collected and monitored to ensure the safety of residents. The programme includes accident and incident reporting, infection control surveillance, internal audits, hazard identification and management. Outcomes are presented and discussed at the monthly staff meetings. Corrective actions are issued as part of the audit process. Risks and management processes are identified and documented in a risk management plan and a hazard register. Internal and external stairs from the upstairs wing need to be added to the hazard register. This is an area requiring improvement. Documented procedures are followed for the recruitment, orientation and monitoring of staff performance. Staff attend a regular in-service training programme that addresses subjects related to the care of the older person. The training programme is well attended. Staffing levels follow documented acuity care levels and meet ARRC requirements. The staff roster has recently been changed due to a change in the care needs of residents. An additional caregiver now works from 7.00am to midday each morning. Each resident has an integrated record of care. The facility is required to ensure that all resident documentation is completed on site to protect the privacy of residents. This is an area requiring improvement.

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

Resident files reviewed include service coordination centre assessment forms. The facility information pack 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. A comprehensive assessment, including a variety of risk assessments, are completed on admission and reviewed six monthly or more frequently if required. An initial care plan guides staff prior to a long term care plan being developed. Residents and/or family have input into the development of care plans. Planned activities are appropriate to the residents' interests and are provided in the mornings. Residents interviewed confirm their satisfaction with the programme. A social profile is completed on admission and activities progress notes/evaluations are recorded. Improvements are required whereby individual activity care plans are developed to include goals and interventions. Activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. Policies and procedures around medication detail service provider's responsibilities. Registered nurses and senior caregivers who are responsible for medication administration have attended in-service education for medication management and complete a medication competency annually. Medication charts sighted evidence documentation of consumers' allergies/sensitivities and three monthly medication reviews completed by general practitioners. Medications are managed in line with good practice and guidelines. Controlled drugs are safely stored and administered and residents who self-administer medications are assessed for competency three monthly. The service has transfer and discharge procedures the 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. All food is cooked on site and kitchen staff have completed safe food handling training. Residents and families interviewed all confirmed satisfaction with food services.

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

Halldene displays a current building warrant of fitness which expires on 7 June 2015. Scheduled and reactive maintenance is carried out. Bulk chemicals are stored in a locked storage compartment in the laundry. Improvements are required around ensuring that decanted cleaning chemicals are labelled and stored securely. Hot water is monitored and recorded and are maintained within acceptable limits. Improvements are required whereby medical equipment including hoists and blood pressure machines, are serviced and calibrated by an authorised technician. Residents' rooms are of varying sizes. There are nine shared rooms both upstairs and down stairs. The majority of rooms have full ensuite. Improvements are required whereby all communal bathrooms have working privacy locks. There is sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. The service is divided into three wings. There is a lounge and dining area in each wing, and smaller seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. All resident rooms, communal areas and bathrooms are able to cater for residents requiring hospital level care. Cleaning and laundry is completed by care staff and audits are conducted to assess effectiveness and satisfaction. There are appropriate emergency and civil defence management plans and resources in place and staff are trained in first aid and fire evacuation. Procedures are in place to protect the safety of residents and visitors. These include regular staff training on emergency management, fire evacuation practices and the regular maintenance of equipment and buildings. Essential supplies are stored in the event of an emergency. A call bell system operates throughout the building. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, ramps, rails, seating and shade provided. Smoking is only permitted in designated external areas.

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

The restraint minimisation and safe practice policy states that Halldene Residential Care is committed to a restraint free environment. The policy describes the methods of enablers and restraint permitted within the facility. The clinical auditor is the restraint coordinator. Prior to the use of restraint all measures are taken to consider other options. The application of restraint requires the approval of the clinical auditor, after discussion with the medical practitioner, the resident (where possible) and the family. The use of restraint is recorded, monitored and evaluated. Staff are trained in the use of restraint and the management of challenging behaviour.

#### **Outcome 3: Infection Prevention and Control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access.

Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator (clinical auditor) has attended infection prevention education. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	44	0	6	0	0	0
<b>Criteria</b>	0	95	0	6	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0	0	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.9	Actual and potential risks are identified, documented and where appropriate communicated to	PA Low	There is an internal stairway leading from the lower wing to the upstairs wing. Three doors from the	Identify and record all potential and actual hazards. Ensure that hazards are appropriately	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(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;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>upstairs wing lead to a balcony, with stairs leading to the decked area. These stairs are not included in the hazard register and have not been managed via the hazard management process.</p>	<p>managed to provide a safe environment for staff and residents.</p>	
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.7	Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.	PA Low	The activities' coordinator is taking resident activity care plans home to complete them.	Ensure all resident related documentation is maintained in a secure manner that is not publicly accessible or observable.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		promote continuity of service delivery.				
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	Of the seven files reviewed (two rest home and five hospital), none of the seven evidenced that activities goals and plans have been developed.	Ensure that activity goals and plans are developed for every resident.	90
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	Decanted chemicals in portable spray bottles are not labelled and cleaning bleach was left in a downstairs communal toilet	Ensure all chemicals are appropriately labelled and all chemicals are stored securely.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	A) Medical equipment has not been calibrated or checked by an authorised technician and includes blood pressure monitors, oxygen concentrator, thermometer; b) hoists have not been checked or serviced in the past 12 months. Advised by the new owners that a technician has been booked to attend to these matters.	a) Ensure that all medical equipment is checked and calibrated by an authorised technician as per manufacturer's instructions; b) ensure that hoists are checked and serviced annually.	60
HDS(C)S.2008	Standard 1.4.3: Toilet, Shower, And Bathing Facilities	Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	PA Low			
HDS(C)S.2008	Criterion 1.4.3.1	There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing	PA Low	Two communal toilets/shower rooms do not have locks that are in good working order.	Ensure that communal bathroom facilities maintain resident's privacy.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		facilities designated for service providers or visitor use.				

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

The policy on resident rights addresses the requirements for the implementation of the Code of Health and Disability Services Consumers' Rights (the Code). Staff attended in-service training on the Code on 12 March 2013 and 3 October 2014. Resident rights are also addressed during orientation. An audit of the Code of Rights was completed in February 2014. Caregivers are familiar with the requirements of the Code and apply this when working with residents (verified during interview with five of five caregivers).

### 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:**

Pamphlets describing the health advocacy service are displayed in the facility. Information about advocacy is included in the resident information pack. Residents and/or their family sign that they have received the pack. The content of the pack is discussed with the new resident and their family prior to, or at the time of, admission. Monthly residents' meetings are held in the facility.

Documentation verifies that the facility met with a family member and a person from Age Concern in July 2014, in response to a complaint.

The summary of the resident/relative satisfaction survey, completed by 13 respondents in November 2013, confirms that residents and/or their relatives understand advocacy procedures. Relatives and residents state that they are involved in the care of the resident and are included in the review of care plans (verified during interview with nine of nine residents and five of five relatives).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies on independence and individuality, spirituality of the older person, resident's choice, sexuality and intimacy, confidentiality, privacy and dignity address procedures to support the dignity, privacy and independence of the resident. The residents who share a double room (other than those shared by a husband and wife) sign a form on specific consent to share a room. Curtains are placed in all shared rooms. Staff were observed knocking on resident's doors before entering their room. There is a small lounge in the upstairs wing that can be used for quiet discussions. This is accessible by a lift.

CCTV cameras, used for the security of residents and staff, are placed in the shared areas in each of the three resident wings, the kitchen and the laundry. At night an associated speaker system alerts staff when a resident leaves their room. The monitor is placed in the office on the lower floor. Notices informing people of the presence of the CCTV cameras are posted in each area where cameras are located. A video camera procedure describes the reason for the use of CCTV cameras and monitoring processes.

There is a policy on the care, loss and damage to personal effects. In the event that a resident leaves the facility temporarily their belongings remain in their room.

The cultural and spiritual needs of the residents are identified on admission and are documented in their care plans (sighted in seven of seven resident's files – two rest home and five hospital level). A weekly church service is held at the facility. Key religious events are celebrated, for example Christmas and Easter. Residents and relatives interviewed report privacy, dignity and respect are maintained.

The level of independence/dependence of each resident is documented. Residents are supported to maintain independence. One relative interviewed describes how her father was provided with care and support to enable him to start walking again after a stroke. Caregivers encourage residents to attend to activities of daily living wherever possible.

The policy on resident's safety and abuse prevention and security defines the type and signs and symptoms of abuse and neglect and reporting processes. Abuse and neglect is addressed during orientation. There have not been any reports of abuse or neglect.

A residents' meeting is held monthly. The summary of the resident/relative satisfaction survey confirms that the residents' privacy and dignity respected. Relatives state that they are very happy with the care and support given to residents (verified during interview with five relatives).

Staff sign a confidentiality agreement at the time of employment. Staff attended training on privacy and dignity and cultural safety on 12 August 2014 and abuse and neglect on 3 September 2012. Caregivers are familiar with privacy requirements and are aware of how to recognise the signs of abuse and reporting processes (verified during interview with five of five caregivers).

#### **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 policy on the Treaty of Waitangi, guidelines for the provision of culturally safe services for Maori residents and Maori values and concepts (Tikanga) guide staff in the appropriate care of Maori residents.

The facility has contacted Te Ha O Te Oranga O Ngati Whatua to enquire about services available to any Maori residents. This provider does not provide its services in Whangaparaoa. The facility intends to contact another Maori provider located on the North Shore.

Entertainment includes students from a nearby school who present the Haka and waiata.

At the time of the audit there was one Maori resident who is under the care of the Public Trust. A Maori care plan had been completed. The resident states that she is happy with care she receives and her cultural needs are respected (verified in interview with the resident). A staff in service on residents who identify as Maori is planned for 21 August 2014.

### 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:**

There is a policy on cultural safety and a document describing cultural responsiveness for a range of cultures. The cultural needs, values and beliefs of the residents are identified on admission and are documented in their care plans (sighted in seven of seven resident's files). Cultural support is addressed in the resident information pack.

Family are encouraged to participate in the care of the resident (verified during interview with five of five relatives). Visitors were observed on the days of the audit. Family members are invited to celebratory events including birthdays, the weekly happy hour, carol singing and entertainment. Cultural groups provide entertainment. There is a weekly church service at the facility. The summary of the resident/relative satisfaction survey held in November 2013 confirms that the residents' individual values and beliefs are met.

Residents and relatives interviewed report that their individual values and beliefs are upheld.

### 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 a staff code of conduct and a disciplinary process. The house rules are addressed during orientation. Each role has a job description that describes areas of responsibility and key tasks. Each employee has an annual performance appraisal. The facility manager ensures that performance appraisals are completed according to a monthly schedule. Caregivers are familiar with their professional boundaries (verified during interview with five of five caregivers). Relative's and residents state that the staff are professional and provide very good care (verified during interview with nine residents (four rest home and five hospital) and five relatives (one rest home and four hospital)).

### 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:**

All policies and procedures are based on best practice and are developed and updated by an independent aged care advisor from the Care Association of New Zealand (CANZ). Updated policies are discussed at the staff meetings and placed on a clipboard in the nurses' station, to be read by staff. The regular in-service training programme is well attended. Hand-outs on the topic discussed are distributed. Facilitators include the independent aged care advisor, geriatric specialist nurses, hospice nurses and the clinical auditor. The clinical auditor and registered nurses attend external courses related to their role. A set of competencies, for example hoist, restraint, infection control and hand washing are completed two weeks after employment and then annually to ensure that best practice is maintained.

Relative's and residents state that the staff are professional and provide very good care (verified during interview with nine residents (four rest home and five hospital) and five relatives (one rest home and four hospital)).

### 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:**

There is an on open disclosure policy and an interpreter policy. All incident reports document whether the family has been informed. Discussions with relatives are recorded in complaints' documentation.

Relatives state that they are kept informed about incidents and/or changes in a resident's condition (verified during interview with five of five relatives). The summary of the resident/relative satisfaction survey held in November 2013 confirms that relatives are given a clear explanation of any incident, including what happened and actions taken.

Interpreter services are available through the DHB, although these have not been required.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

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

D16.4b: Five family members stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Haldene has policies and procedures relating to informed consent and advanced directives. A review of seven files (two rest home and five hospital) identified that all seven files included signed informed consent forms to allow for taking of photographs, collecting health information and outings as part of the admission process and agreement. There are resuscitation policies and procedures in place. Resuscitation decisions are discussed with residents and families and this is documented. Resuscitation policy states that all residents are regarded as being 'for resuscitation' unless an explicit decision has been made in advance by the resident, or if a medically initiated 'do not resuscitate' has been documented. For those residents who are unable to make a decision, then the default option is that they are for resuscitation. Informed consent forms are completed for those residents who share a bedroom and these were sighted as completed appropriately. There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with five relatives (one rest home and four hospital) relatives identified that the service actively involves them in decisions that affect their relatives' 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:**

Pamphlets describing the health advocacy service are displayed in the facility. Information about advocacy is included in the resident information pack. Residents and/or their family sign that they have received the pack. The content of the pack is discussed with the new resident and their family prior to, or at the time of admission as confirmed by residents and relatives interviewed. Monthly residents' meetings are held in the facility.

Documentation verifies that the facility manager met with a family member and a person from Age Concern in July 2014, in response to a complaint.

The summary of the resident/relative satisfaction survey, completed by 13 respondents in November 2013, confirms that residents and/or their relatives understand advocacy procedures. Relatives and residents state that they are involved in the care of the resident and are included in the review of care plans (verified during interview with nine residents (four rest home and five hospital) and five relatives (one rest home and four 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:**

People were observed visiting residents during the audit. Residents can participate in a lunch outing to the RSA every two weeks. There is a weekly church service at the facility. Other community groups who visit the facility include school groups and musicians. Relative's state that they can take the resident on an outing, can visit at any time and are made to feel welcome (verified during interview with five of five relatives).

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints policy and flowchart meets the requirements of Right 10 of the Code. Staff attended training on complaints management on 11 August 2014 and an audit of the complaints procedure was completed in February 2014.

Information about the complaints process is provided in residents' information pack. Copies of the complaints form are located on a notice board near the entrance to the facility.

The facility has received a total of eight complaints for the period February 2011 to July 2014. Two were received in 2014. The complaints' register records the date received, the name of the complainant and the resident, the date actioned and the outcome. Documentation related to each complaint includes records of the investigation including discussions and a letter of acknowledgement and a final letter to the complainant within the timeframes described in right 10 of the Code. Two complaints received in 2014 were related to concerns about staff response during the care of a resident (discussions with the daughter and an Age Concern representative resulted in the development of a new care plan that was approved by the daughter) and the loss of a piece of jewellery. The facility manager discussed the latter complaint with the DHB programme manager and on her advice completed an incident notification form on the possible theft of residential property. The family informed the Police. There are no outstanding complaints and there are no complaints with the health and disability commission.

### **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:**

Haldene provides rest home and hospital level care for up to 37 residents. The service intends to use five beds that are currently for rest home only use for rest home or hospital level use. On the day of audit there were six rest home residents and 31 hospital level residents. This provisional audit was conducted to assess the preparedness of new owners for the facility and included an interview with the new area manager, review of the transition plan and interviews with the current facility manager, clinical auditor and care staff. The new owners, CHT, have 10 other facilities across the Auckland area. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures.

The business plan (14 May 2014) is approved by the owners of the facility and addresses 10 key objectives. The development of a business plan was identified as an area for improvement in the previous audit. The philosophy and mission statement is described in the residents' information pack and in the information provided during orientation of new staff.

The facility manager has been in the position for four years. She completed nursing training in Slovenia and Austria, but is not a New Zealand registered nurse. A job description describes her responsibilities. She has completed in excess of eight hours management related training in the past year. This includes a course on motivating your people, attendance at two CANZ professional development seminars and infection control management. The facility manager is supported by a clinical auditor and five registered nurses who have current practising certificates.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has policies and procedures to guide practice that are appropriate for rest home and hospital level care.

D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement and risk management programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

The clinical auditor (a registered nurse with a current practising certificate) performs the role of manager during the temporary absence of the facility 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:** PA Low

**Evidence:**

Halldene Residential Care has a quality policy statement and procedures for quality and risk management and corrective action processes. The quality and risk management plan describes the facility's quality objectives and identifies key risks and associated management controls.

There is a policy and flowchart on the control of documents and records. All policies and procedures are developed and updated by an independent aged care advisor from CANZ. Updated policies are discussed at the staff meetings and placed on a clipboard in the nurses' station, to be read by staff. All policies have a title, a review and issue number and a page number. All policies have been reviewed within the past two years. Policy manuals are located in the nurses' office.

Monthly analyses and reports are completed and include falls, skin tears, infection control, behaviour incidents, other injuries, unintentional weight loss, absconding and medicine errors. Corrective action reports are completed when there is an increase in reporting, audit gaps are identified or the family expresses a concern. For example, in response to an increase in reported medicine errors in July 2014 the medicine policy was reviewed with the registered nurses and new medicine competencies were completed.

There is a procedure on audits, review and calibration. An annual audit schedule is implemented. All audits are documented. Recent audits include cleaning, laundry services and a resident file audit. A resident/relative satisfaction survey was completed in November 2013. The results were published in a newsletter sent to relatives in December 2013.

There are monthly meetings for registered nurses and team leaders and monthly staff meetings. The agenda of staff meetings includes complaints, restraint, infection control, health and safety, audits and corrective actions, internal failures, risks and hazards and training (monthly minutes sighted for January to August 2014). The monthly analyses are discussed at meetings and are displayed on the noticeboard in the nurses' office.

The facility manager has monthly meetings with the owners of the facility.

The hazard register identifies hazards that cannot be eliminated. There is an internal stairway leading from the upstairs wing to the lower wing. Three doors from the upstairs wing lead to a balcony with stairs leading to the decked area. These stairs are not included in the hazard register and have not been minimised or isolated. This is an area requiring improvement.

Caregivers are informed about reported events and policy changes (verified during interview with five of five caregivers).

**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.

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**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:** PA Low

**Evidence:**

The quality and risk management plan describes the facility's quality objectives and identifies key risks and associated management controls. Hazard registers are in place for the kitchen, laundry, residents, staffing, financial and environment. There is an internal stairway leading from the lower wing to the upstairs wing. Three doors from the upstairs wing lead to a balcony, with stairs leading to the decked area.

**Finding:**

There is an internal stairway leading from the lower wing to the upstairs wing. Three doors from the upstairs wing lead to a balcony, with stairs leading to the decked area. These stairs are not included in the hazard register and have not been managed via the hazard management process.

**Corrective Action:**

Identify and record all potential and actual hazards. Ensure that hazards are appropriately managed to provide a safe environment for staff and residents.

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

Halldene Residential Care is familiar with notification requirements including a change in manager, sudden death, serious harm and a reporting a notifiable disease. The facility has copies of the Ministry of Health reportable event brief form and the notice of an uncontrollable event.

Policies on health and safety, accidents and incidents, accident investigation, notification of accidents, visitors' safety and hazard management are in place. Accidents and incidents are recorded on the accident/incident report form (sighted for July 2014). The report documents the nature of the problem, the event, contributing factors, actions taken and whether the relative was informed. All reports are signed by the clinical auditor when action is completed.

Staff attended in-service training on health and safety and hazards on 20 February 2014. Caregivers are familiar with reporting requirements (confirmed during interview with five of five caregivers). Family state that they are informed about incidents or accidents (verified in interview with five of five relatives).

D19.3c Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical auditor and the five registered nurses have current practising certificates. Copies of current practising certificates are also held for the doctor and podiatrist. A copy of the pharmacy license is held for the pharmacist.

There are policies on induction/orientation, written applications, interview, reference checks, and Police vetting and staff in-service education. There is a comprehensive orientation process that addresses key tasks, responsibilities and procedures and includes a buddy system. Each employee completes an application, provides curriculum vitae and has an interview. Two reference checks and a police check are completed (sighted in seven of seven personnel files – four caregivers, the clinical auditor and two registered nurses). Where appropriate, copies of current work visas are placed in personnel files.

There is an annual training plan (sighted for 2013 and 2014). The regular in-service training programme addresses a range of topics related to the care of the older person and is well attended. Facilitators include the independent aged care advisor from CANZ, geriatric specialist nurses, hospice nurses and the clinical auditor. The clinical auditor and registered nurses attend external courses related to their role, for example the clinical auditor and a registered nurse have completed an InterRAI course. Information about education programmes offered by West Auckland and North Shore hospices is posted in the nurses' office. A set of competencies, for example, hoist, restraint, infection control and hand washing are completed two weeks after employment and then annually. Caregivers do not currently participate in a NZQA training course. The potential new owners offer Aged Care Education (ACE).

### 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 policy on staffing levels and skill mix states “staffing will be at a level that reflects the number and mix of residents, acuity of residents, care levels the layout of the facility and staff skills and experience.”

Resident areas are located on three levels – the lower and right wings (on the ground and lower floors) are connected by an internal ramped area which has a gradual gradient and the upstairs wing which is accessed by a lift or stairs.

Of the 14 caregivers, eight have been employed since February 2014. A number have English as their second language. The five registered nurses have been employed for periods ranging from three years to nine months.

The number of caregivers on duty has recently been increased due to the needs of the residents. On 26 July 2014 the caregivers were increased from four to five on the 7.00 am to 10.00 am shift for that weekend. On 7 August 2014 an additional caregiver was added to the 7.00 am to midday shift due to an increase in the number of resident falls. On 4 August 2014 an additional caregiver was permanently added to the roster for the 7.00am to midday shift, seven days a week. The facility manager occasionally works as a caregiver on a shift, for example for the period 18 to 24 August she is working three shifts from 7.00am to midday. The facility is currently advertising for more caregivers.

The clinical auditor and facility manager provide on call response.

The caregivers state that they work as a team and are able to meet the needs of the current residents (verified during interview with five of five caregivers).

The roster meets ARRC requirements.

The registered nurse decides the location of staff during night shift.

**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.

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

**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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>There is a policy on the collection, usage, storage and security of information. Hard copy resident files are integrated and are in place for each resident. Progress notes are completed on each shift. All information is entered in a timely manner, is accurate and appropriate to the resident's care needs. All records are legible and signed with the name and designation of the person making the entry (verified during review of seven resident files (five hospital level and two rest home). Current resident records are stored on shelving next to the receptionist and in a locked filing cabinet adjacent to the nurses' office. The activities coordinator advised that she takes resident activities care plans home to complete them. This is an area requiring improvement. Medication charts are stored separately. Archived records, are stored in a locked storage cupboard in the upstairs wing. Archived records are labelled for easy identification.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**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:** PA Low

**Evidence:**

There is a policy on the collection, usage, storage and security of information. Hard copy resident files are integrated and are in place for each resident. Progress notes are completed on each shift. All information is entered in a timely manner, is accurate and appropriate to the resident's care needs. All records are legible and signed with the name and designation of the person making the entry (verified during review of seven resident files (five hospital level and two rest home). Current resident records are stored on shelving next to the receptionist and in a locked filing cabinet adjacent to the nurses' office.

**Finding:**

The activities' coordinator is taking resident activity care plans home to complete them.

**Corrective Action:**

Ensure all resident related documentation is maintained in a secure manner that is not publicly accessible or observable.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Nine residents (four rest home and five hospital) and five relatives (one rest home and four hospital) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for seven resident files sampled (two rest home and five hospital). The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission 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. Halldene records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency. The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Registered nurses are responsible for conducting assessments and developing care plans. Comprehensive nursing assessments and risk assessments are completed and form the basis of the long term care plan. Reviews are conducted six monthly or earlier if resident health changes. These are conducted by the registered nurse with input from the care staff, activities coordinator, general practitioner (GP) and relatives. Handover occurs at the end of each duty that maintains a continuity of service delivery. There are communication books which staff read. The facility manager and clinical share on call after hours and at weekends. Medical assessments are completed within two working days of admission by the GP as evidenced in seven of seven files sampled (two rest home and five hospital). It was noted in residents files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. The GP interviewed stated that the service contacted him in a timely manner, providing information required to assess the residents. The service always carried out any observations and interventions as prescribed. The service has recently commenced using InterRAI and the clinical auditor reports that she has completed the InterRAI training. One other registered nurse (seven RN's in total) is in the process of completing the training. Long term care plans reviewed for seven files sampled evidenced comprehensive and resident focused goals and interventions. All seven files identified integration of allied health. The sample of files reviewed included two rest home and five hospital residents.

Tracer Methodology Rest Home:

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

Tracer Methodology Hospital:

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:**

Ensure that all residents have regular RN input that this is documented, and that RN's follow up all appropriate issues and document this in the resident file.

**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:**

In seven of seven files sampled (two rest home and five hospital), an initial nursing assessment and initial care plan is completed within 24 hours of admission. A comprehensive nursing assessment is conducted which forms the basis of the long term care plan. This assessment includes activity level, orientation, sleep patterns, mobility, nutrition, elimination, perception, mental ability, behavioural assessment, depression, pain, social history, skin integrity, sexuality/privacy, values/beliefs, and orientation to the facility. Further risk assessments are conducted around pain, falls, pressure area, nutrition, and continence. The long term care plan is completed within three weeks as evidenced in seven of seven care plans reviewed. The data gathered is then used to plan resident goals and outcomes including showering, grooming and dressing, mouth care, night care, mobilising, skin care, eating/drinking, elimination/continence, communication, awareness/confusion, restraint/challenging behaviours, wandering, pain, social, spiritual, sexuality and intimacy, cultural, specific illnesses and end of life care. Assessments are conducted in an appropriate and private manner. Nine residents (four rest home and five hospital) reported being satisfied the support provided. Assessments are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessments process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessments and care plans. Residents and relatives interviewed stated they were informed and involved in the assessment process. The assessment tools link to the individual care plans. The care plans are individualised for each resident need as detailed in the long term care plan. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. The service has recently commenced using InterRAI. The clinical auditor has completed the InterRAI training and a further one registered nurse is in the process of completing the training. None of the seven files reviewed included InterRAI assessments completed at Halldene.

**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 was conducted (two rest home and five hospital). Each file includes: resident medical information, doctors notes, observations, weight monitoring, lab forms, transfer documents, bowel charts, correspondence, NASC assessments, admission forms, family contact sheets, informed consent documents, nursing assessments, nursing action plans, short term care plans, disturbed behaviour plans, risk assessments, social profiles, activities assessments, activities records and evaluations, progress notes and restraint documentation where required. The initial care plan is developed from the initial assessment and identifies areas of concern or risk. The clinical auditor has commenced utilising the InterRAI assessment tool for reassessing residents at Halldene. Resident's comprehensive long term care plans are individually developed with the resident and the family. Nine residents and five family members interviewed stated they were involved in the care planning process. Seven resident comprehensive long term care plans were evidenced to be up to date. Nursing diagnosis, goals and interventions are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to); showering, grooming and dressing, mouth care, night care, mobilising, skin care, eating/drinking, elimination/continence, communication, awareness/confusion, restraint/challenging behaviours, wandering, pain, social, spiritual, sexuality and intimacy, cultural, specific illnesses and end of life care. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. There is evidence that the long term care plans were reviewed six monthly or more frequently if care needs change. On review of seven files, it was noted that all seven files evidenced activities assessment conducted but goals and plans for activities were not documented. Improvements are required in this area. There is evidence that the residents are seen by the GP three monthly if the resident is stable or more frequently as required. The GP notes are well maintained. Short term care plans and additions to the long term care plan are developed for use for acute changes in health status. Examples sighted included infections, wounds, and decline in health status. All seven files evidenced that family were involved.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A review of seven resident files was conducted (two rest home and five hospital). The initial care plan is developed from the initial assessment and identifies areas of concern or risk. The clinical auditor has commenced utilising the InterRAI assessment tool for reassessing residents at Halldene. Resident's comprehensive long term care plans are individually developed with the resident and the family. Nine residents and five family members interviewed stated they were involved in the care planning process. Seven resident comprehensive long term care plans were evidenced to be up to date. Nursing diagnosis, goals and interventions are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to); showering, grooming and dressing, mouth care, night care, mobilising, skin care, eating/drinking, elimination/continence, communication, awareness/confusion, restraint/challenging behaviours, wandering, pain, social, spiritual, sexuality and intimacy, cultural, specific illnesses and end of life care. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. Social profiles and activities assessments are conducted.

**Finding:**

Of the seven files reviewed (two rest home and five hospital), none of the seven evidenced that activities goals and plans have been developed.

**Corrective Action:**

Ensure that activity goals and plans are developed for every resident.

**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:**

Halldene provides services for residents requiring rest home and hospital care. Individual care plans are completed. The five caregivers, two registered nurses and one clinical auditor interviewed stated that they have all the equipment referred to in the long term and short term residents care plans necessary to provide the care required. These include wheelchairs, walking frames, weighing scales, transferring equipment pressure relieving equipment, residents safety equipment, electric beds, continence supplies, gowns, masks, aprons and gloves. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. On the day of the audit supplies of these products were sighted (calibration and servicing of equipment is overdue as per #1.4.2.1). There are currently six wounds being treated including one ankle pressure area, one acquired sacral pressure area, two nephrostomy sites, and two ulcers. Wound assessments, management plans and evaluations were completed and evidenced for all wounds. The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service provided in July 2013 and July 2014 and wound management in-service provided in June 2014. All falls are reported on the incident forms and reported to the registered nurse/clinical auditor. Falls risk assessment is completed on admission and reviewed six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required. There are registered nurses employed 24/7 by the service as well as a clinical auditor and a facility manager. A record of all health practitioners practising certificates is kept. Resident's needs are assessed using pre admission documentation, doctor's notes and the assessments tools which are completed by a registered nurse. Care plans are goal orientated and reviewed six monthly. Care plans are updated to reflect intervention changes following review or change in health status. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents and relatives interviewed were able to confirm that privacy and dignity was maintained

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

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

**Attainment and Risk:** FA

**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 one activities coordinator at Halldene who are responsible for the planning and delivery of the activities programme and has been in the role for two years. The coordinator works Monday to Friday for 2.5 hours each morning. The activities coordinator plans the monthly programme with assistance from the facility manager and clinical management. Activities are provided in the lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved one to one activities, newspaper reading and watching a movie. The programme is developed monthly. 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 with family involvement. Of the seven files reviewed, none of the seven evidenced that activity goals and plans were developed (link #1.3.5.2). The programme includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident's activities and monthly progress notes completed. There is a wide range of activities offered that reflect the resident needs including but not limited to: bowls, housie, craft, board games, cards and knitting, baking, tenpin bowling, lunch club, van outings, and happy hour. Participation in all activities is voluntary. The activity programme is displayed on the resident's notice board and discussed at monthly resident meetings. Halldene has its own van for transportation. The activity staff have current first aid certificates.

### **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:**

All initial care plans were developed by the registered nurse on the day of admission and residents comprehensive long term care plan developed within three weeks of admission. Long term care plans are evaluated six monthly or more frequently if there is a significant change in health status. There was documented evidence that care plan evaluations were up to date in all seven files sampled. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by the registered nurse. There is at least a three monthly review by the medical practitioner or when requested if issues arise or health status changes. One house GP interviewed stated that the communication from the service is appropriate and in a timely fashion and that the service carries out instructions. They advised that they have confidence in the skills and knowledge of the clinical auditor and registered nurses to safely care for residents. Short term care plans were evident for current and previous wounds, skin tears, bruising, infections and changes in health status. STCPs reviewed evidence evaluation and are signed and dated by the registered nurses when issues have been resolved. 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.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The registered nurses described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, GP, speech language therapist, and mental health services for older persons, Discussions with the clinical auditor identified that the service has access to wound care nurse specialists, incontinence specialists, dietitian, podiatrist and physiotherapist.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

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

Progress notes document 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:** FA

**Evidence:**

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accordance with the guidelines: 2011 medicines care Guides for Residential care.

The service has policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by the GP. Halldene uses the four weekly blister pack system. Medication charts record prescribed medications by the residents' general practitioner and these are kept in the medication folders. The medication folders include specimen signatures. There is a signed agreement with the pharmacy. Medications are delivered by the pharmacist and are checked on arrival by a registered nurse. Any pharmacy errors recorded and fed back to the supplying pharmacy. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. The service uses standing orders which are reviewed annually by the GP (last reviewed July 2014). Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for: a) allergies and duplicate names. Education on medication management occurred in July 2014 as part of the service's response to medication errors and policy review. Registered nurse and senior caregiver competencies include warfarin, insulin, controlled drugs and general medications administration. A tracking process is in place to ensure competencies are completed and this is managed by the assistant manager. Medication charts have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication. Two registered nurses were observed administering medications safely and appropriately – checking the medication chart, identifying the resident, administering the medication, observing that this is taken and then signing for the medications. The service does not have a designated medication fridge, however, medications are stored in sealed and labelled containers in the kitchen chiller. One resident is self-medicating eye drops. The resident has been assessed as competent to do so and this has been reviewed three monthly.

There is one medication trolley which is locked when not in use. There is a medication/treatment room upstairs, and a locked medication cupboard in the nurse's station which also houses the controlled drug safe. Controlled drugs are appropriately managed with two medication competent persons signing out for all controlled drugs. There is evidence that weekly controlled drug checks and six monthly drug stocktake has been completed. There are no residents receiving regular controlled drugs – only PRN controlled drugs. Staff sign for the administration of medications on medication signing sheet. 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. Registered nurses and senior caregivers administer medicines. There is a signed agreement with the pharmacy.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Haldene food service is provided on site in a centrally located kitchen. There are two cooks and three kitchen hands that have all completed safe food handling training. Meals are served directly to residents in the ground floor wings and plated and covered on trays and transported to the upstairs dining room. Temperature of hot food is checked prior to serving to residents. Evidence of this was sighted. Daily temperature checks are taken of the fridge, chiller and freezer. There is a summer and winter four week rotating menu and this has been approved in March 2013 by a dietitian. 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. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. There is stores of food on site which includes snacks such as bread, eggs, sandwiches, cheese and biscuits. Food sighted in the fridges was covered and dated.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to kitchen by the clinical auditor as reported by the cook interviewed. A copy of residents dietary requirements are available in the kitchen (sighted). Special diets being catered for include pureed diets, vegetarian and soft diets. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, meals are well presented. Alternative meals are offered as required and individual resident likes and dislikes are noted in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. Residents/relatives meeting include discussion on the food service and feedback to the kitchen.

The kitchen service is well able to cater for an additional five residents at hospital level care.

**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.

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**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:** PA Low

**Evidence:**

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. Bulk chemicals are labelled with manufacturer labels, however, decanted chemicals in portable spray bottles are not labelled. Improvements are required in this area. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely in the laundry. It was noted that cleaning bleach was left in a downstairs communal toilet. Improvements are required in this area. The sluice is located in the dirty area of the laundry which is secure when not in use. Material safety data sheets are available. Hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Interviews with five caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in March 2014.

**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:** PA Low

**Evidence:**

There are policies in place in for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. Bulk chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely in the laundry. The sluice is located in the dirty area of the laundry which is secure when not in use. Material safety data sheets are available. Hazard register identifies hazardous substances.

**Finding:**

Decanted chemicals in portable spray bottles are not labelled and cleaning bleach was left in a downstairs communal toilet

**Corrective Action:**

Ensure all chemicals are appropriately labelled and all chemicals are stored securely.

**Timeframe (days):** 30 (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:** PA Low

### **Evidence:**

The service displays a current building warrant of fitness which expires on 7 June 2015. Hot water temperatures checks are conducted in each resident bathroom and basin and recorded monthly by the facility manager. The fire evacuation scheme was approved in 1999. Fire drills are conducted (last provided in 22 July 2014). Chair scales were purchased in October 2013. There is one standing hoist and one sling hoist. Both are overdue for servicing and checking. Medical equipment requires calibration and checking including blood pressure monitors, oxygen concentrator, and thermometer. Improvements are required in these areas. Annual testing and tagging of electrical equipment has been conducted in June 2014. The interior is maintained with a home-like décor and furnishings. There are three lounges and three dining areas with other small sitting areas. There are 28 resident rooms in the facility – nine of which are double rooms. Three of these are occupied by married couples. There is a mixture of fully ensuite rooms and communal toilets and showers. The communal toilets and showers facilities are within easy access of resident rooms. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. Resident rooms, communal areas and bathrooms are able to cater for the extra needs of hospital level residents being assessed as part of this audit. There is an external designated smoking area. There is easy access to the outdoors. Outdoor ramps have handrails. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with five caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

### **Evidence:**

The service displays a current building warrant of fitness which expires on 7 June 2015. Hot water temperatures checks are conducted of each resident bathroom and basin and recorded monthly by the facility manager. The fire evacuation scheme was approved in 1999. Fire drills are conducted (last provided in 22 July 2014). Chair scales were purchased in October 2013. Annual testing and tagging of electrical equipment has been conducted in June 2014. .

### **Finding:**

A) Medical equipment has not been calibrated or checked by an authorised technician and includes blood pressure monitors, oxygen concentrator, thermometer; b) hoists have not been checked or serviced in the past 12 months. Advised by the new owners that a technician has been booked to attend to these matters.

### **Corrective Action:**

a) Ensure that all medical equipment is checked and calibrated by an authorised technician as per manufacturer's instructions; b) ensure that hoists are checked and serviced annually.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** PA Low

**Evidence:**

There are 28 resident rooms – nine of which are double rooms. Nine of the rooms have full ensuites, and there is one communal shower/toilet on the downstairs area and one in the upstairs area. They are of sufficient size to use mobility and transfer equipment. The number of toilets and showers provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Bathrooms are able to cater for the extra needs of hospital level residents being assessed as part of this audit. Regular audits are completed and included in the quality programme. Nine residents (four rest home and five hospital) interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable. It was noted that the communal toilets – one upstairs and one down stairs do not have locks that are in good working order. Improvements are required in this 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:** PA Low

**Evidence:**

There are 28 resident rooms – nine of which are double rooms. Nine of the rooms have full ensuites, and there is one communal shower/toilet on the downstairs area and one in the upstairs area. They are of sufficient size to use mobility and transfer equipment. The number of toilets and showers provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Nine residents (four rest home and five hospital) interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets.

**Finding:**

Two communal toilets/shower rooms do not have locks that are in good working order.

**Corrective Action:**

Ensure that communal bathroom facilities maintain resident's privacy.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The rooms are spacious enough to meet the assessed resident needs including residents at hospital level care. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.

#### 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 maneuver with the assistance of their aid within their personal space/bed area.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There are three lounges and three dining areas for resident use as well as a large decking area which encircles the facility. Other small seating nooks are in each wing. The down stairs dining room is located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the

consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and nine residents interviewed report they can move around the facility and staff assist them if required. Communal areas are able to cater for the extra needs of hospital level residents being assessed as part of this audit.

#### **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:**

Halldene has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff attend to cleaning duties. Manufacturer's data safety charts are available. Nine residents and five relatives interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Resident satisfaction survey conducted in August 2014 included questions around satisfaction with laundry processes. Laundry audit conducted in May 2014 and cleaning audit conducted in February 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies on visitors, hand call bells, emergency lighting and safety and security address safety procedures. Halldene Residential care has an emergency procedure that addresses emergency planning and preparedness for a range of emergency events including fire, a pandemic event and natural disasters. The fire evacuation scheme was approved by the Fire Service on 29 September 1999. Fire evacuation practices were held on 23 May and 20 December 2013 and 26 June 2014. Staff attended training on emergency management and security on 24 April 2013 and fire safety on 22 January and 23 May 2013 and 22 July 2014. The location of fire alarms and equipment, emergency exits and procedures are addressed during orientation. The resident information package addresses fire evacuation and safety management. Chubb monitors all fire and emergency equipment, including emergency lighting, monthly (sighted for January to July 2014). Appropriate fire signage and fire equipment was placed throughout the facility. A safety audit was completed in January 2014. Sufficient water is stored in water barrels placed on the deck to meet the needs of residents and staff for a three day period. The civil defence kit is checked every six months. Supplies include batteries, candles, a radio, torches (including two that do not require batteries) and LED lights. Three days' supply of food is stored in the pantry. Gas heaters are used if the power is off for an extended period. There is a small gas cooker and a barbecue available for cooking. Extra blankets are available. Call bells are located in all resident areas. Call bell checks are completed in January, March, July and October each year (records sighted for 2014). Call bells were in use on the two days of the audit. Visitors are asked to sign a visitor's book on entry to the facility. Staff complete security checks of all external doors and windows on the lower floors at 10.00pm and 11.00 pm each day. Windows on the lower floors have safety stays. The clinical auditor and five registered nurses, the facility manager and seven caregivers are first aid trained. Caregivers state that they are trained in the management of emergencies and participate in fire evacuation practices (verified during interview with five of five caregivers) the fire evacuation scheme was approved by the Fire Service on 29 September 1999. Fire evacuation practices were held on 23 May 2013 and 20 December 2013 and 26 June 2014. Staff attended training on emergency management and security on 24 April 2013 and fire safety on 22 January and 23 May 2013 and 22 July 2014. The location of fire alarms and equipment, emergency exits and procedures are addressed during orientation. The resident information package addresses fire evacuation and safety management. Chubb monitors all fire and emergency equipment including emergency lighting, monthly (sighted for January to July 2014). Appropriate fire signage and fire equipment was placed throughout the facility. A safety audit was completed in January 2014. Sufficient water is stored in water barrels placed on the deck to meet the needs of residents and staff for a three day period. The civil defence kit is checked every six months. Supplies include batteries, candles, a radio, torches (including two that do not require batteries) and LED lights. Three days' supply of food is stored in the pantry. Gas heaters are used if the power is off for an extended period. There is a small gas cooker and a barbecue available for cooking. Extra blankets are available. Call bells are located in all resident areas. Call bell checks are completed in January, March, July and October each year (records sighted for 2014). Call bells were in use on the two days of the audit. Visitors are asked to sign a visitor's book on entry to the facility. Staff complete security checks of all external doors and windows on the lower floors at 10.00pm and 11.00 pm each day. Windows on the lower floors have safety stays. The clinical auditor and five registered nurses, the facility manager and seven caregivers are first aid trained. Caregivers state that they are trained in the management of emergencies and participate in fire evacuation practices (verified during interview with five of five caregivers). Policies on visitors, hand call bells, emergency lighting and safety and security address safety procedures. Halldene Residential care has an emergency procedure that addresses emergency planning and preparedness for a range of emergency events including fire, a pandemic event and natural disasters.

**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:**

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated via under floor heating which can be controlled in each resident's room. Nine residents and five relatives interviewed state the environment is warm and comfortable.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation and safe practice policy states that “Halldene Residential Care is committed to a restraint free environment”. The policy describes methods of restraint permitted within the facility including the use and definition of permitted enablers. Restraints used are restricted to bedrails and lap belts. The clinical auditor is the restraint coordinator. At the time of the audit there were no enablers in use and bed rails were being used as a form of restraint for eight residents. .

### 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 restraint minimisation and safe practice policy describes the methods of restraint to be used in Halldene Residential Care, the procedures required before restraint can be started, the restraint duration and approval processes.

At the time of the audit bed rails were being used as a form of restraint for eight residents. One of the eight residents also has a lap belt. Review of the resident file of two of the eight residents (one with bed rails and one with both bedrails and a lap belt) confirms that a discussion was held with relatives. A restraint/enabler pre-assessment form was signed by a family member, the general practitioner and the restraint coordinator.

Staff training on restraint minimisation occurred on 26 March 2013 and 20 May 2014 and the management of challenging behaviour on 11 November 2013. Caregivers state that they are familiar with restraint requirements and the management of challenging behaviour (verified during interview with five of five caregivers).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation and safe practice policy describes assessment processes. These are documented on the restraint/enabler pre assessment form that addresses the need for restraint, what other alternatives have been tried, the reason for the type of restraint chosen, any risks identified and any specific resident needs (including cultural needs) during the use of the restraint and the timeframe for the use of the restraint.

At the time of the audit, bed rails were being used as a form of restraint for eight residents. One of the eight residents also has a lap belt. Review of the resident file of two of the eight residents confirms that a discussion was held with relatives. The restraint/enabler pre-assessment form and the physical restraint/enabler consent form is signed a family member, the general practitioner and the restraint coordinator.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation and safe practice policy states that the use of restraint is a last resort only. The restraint/enabler pre assessment form and the physical restraint/enabler consent form are completed prior to the implementation of each form of restraint. The resident who has both bedrails and a lap belt had documentation related to each type of restraint. When the possible use of restraint is identified the registered nurse discusses this with the clinical auditor. The final decision is made by the clinical auditor in discussion with the resident's family and doctor. The physical restraint/enabler consent form documents the type of restraint and the monitoring intervals. The restraint/enabler pre-assessment form is signed after the assessment process is completed and other alternatives have been tried. Both forms are signed by the relative, the doctor and the clinical auditor. The restraint monitoring form is placed in the resident's file and is signed off at the end of each monitoring period, usually every two or three hours while the restraint is in use (sighted in two of two residents' files). The resident using the lap belt is monitored every 30 minutes while the lap belt is in use (signed monitoring form sighted in the resident's file).

A restraint register documents all restraint in use and includes the name of the resident, the date the restraint was initiated, the type of restraint and the date of review.

Caregivers are familiar with the residents who use the restraint, the type of restraint in use and monitoring requirements (verified during interview with five of five caregivers).

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint minimisation and safe practice policy states the addresses the procedures for the evaluation of each restraint. The review date is recorded on the physical restraint/enabler consent form. Reviews occur every six months unless or every three months if there are concerns. At the time of review a restraint/enabler review/evaluation form is completed. This addresses whether the restraint is line with the care plan, is still required, is the least restrictive option, and the desired outcome has been achieved plus any changes to timeframes for monitoring or use. Any changes are discussed with staff. The evaluation is signed by the clinical auditor. When completed, reviews are also signed by the doctor on the consent review section of the consent form.

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical auditor, the doctor, and the facility manager form the restraint approval group. A cultural or technical advocate would be involved if appropriate. The doctor is consulted prior to the implementation of restraint and at the time of review of the restraint (sighted in two of two resident's files). Restraint is discussed at all monthly staff meetings and a six monthly audit of restraint management is completed. The audit includes a review of all monitoring forms, whether the doctor is involved in the decisions about the use of restraint, whether time limits have been applied and observed, whether relatives were involved in decision making and whether restraint was kept to a minimum and utilised only to promote resident safety and comfort. Review of training needs occurs at the time of each resident's evaluation of restraint use.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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### 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:**

Haldene has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by an external provider and signed off by the clinical auditor who is the service infection control coordinator. The infection control team is representative of the facility and includes all staff. Infection control is an agenda item at the quality/staff meetings. Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff – July 2014. Annual review of the infection control programme was last conducted in January 2014. Hand washing facilities are available for staff and residents throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The clinical auditor (registered nurse) is the infection control (IC) nurse. She is supported by the facility manager, registered nurses and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has attended infection control training. The IC nurse and staff have good external support from the local laboratory infection control team and the GP. The infection control team is representative of the facility and includes all staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are infection control policy and procedures appropriate to for the size and complexity of the service.

D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the manager and assistant manager to ensure best practice information is included. The policies and procedures were last updated and reviewed in May 2013. Halldene 's infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control coordinator (clinical auditor). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in July 2014 in relation to hand washing and hand hygiene, and standard precautions. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. No outbreaks have been reported for the past two years. Any resident suspected of having gastro-enteritis is immediately isolated as a precaution. Residents are informed of infection prevention matters that is appropriate to their needs and this is documented in medical records. The clinical auditor and two other staff members attended an external session on scabies management and precautions in May 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Halldene's infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Results of infection surveillance are graphed and available for staff to view.

**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.

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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