# Albany Rest Home 2004 Limited

## Current Status: 28 July 2014

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

## General overview

Albany Rest Home is a privately owned rest home in Gore. One owner is the nurse manager and the other owner provides maintenance and financial management support. The owners purchased Albany in February 2004 and have implemented a business plan and a quality plan for 2014. The nurse manager is supported by a part time registered nurse and care staff. The service provides rest home level care for up to 25 residents with 18 residents accommodated on the day of audit. Staff turnover is reported as low. The quality and risk management programme is managed by the nurse manager and registered nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identifies 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 documenting communication with families, obtaining informed consent, providing mandatory education, training for the infection prevention and control coordinator, ensuring senior staff have a current first aid certificate, ensuring time frames are adhered to for residents risk assessments and care plan evaluations, ensuring risk assessments are completed for identified resident needs, monitoring of enablers and calibration of medical equipment.

The service has applied for 20 beds to be considered for dual purpose beds for rest home or hospital level care. Improvements are required whereby chair scales are provided for the use of non-ambulatory residents and newly appointed staff to receive orientation/induction and medication competencies prior to occupancy of hospital level care residents.

## Audit Summary as at 28 July 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 28 July 2014

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

### Organisational Management as at 28 July 2014

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

### Continuum of Service Delivery as at 28 July 2014

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

### Safe and Appropriate Environment as at 28 July 2014

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

### Restraint Minimisation and Safe Practice as at 28 July 2014

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

### Infection Prevention and Control as at 28 July 2014

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

## Audit Results as at 28 July 2014

### Consumer Rights

The support provided to residents at Albany Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. There is an improvement required around obtaining informed consent from residents in regards to being part of social media. There is documentation to evidence communication with families however there are improvements required around contacting families following resident’s incidents. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Advanced directives are appropriately recorded. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

### Organisational Management

Albany Rest Home has an organisational philosophy, which includes a vision, mission statement and strategic objectives.

The owners have owned the facility since February 2004. The nurse manager/owner is supported in her role by one other owner, a part time registered nurse and care staff. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. There are improvements required around providing education for staff including abuse and neglect, cultural safety, wound care and safe handling of chemicals. Staffing levels are safe and appropriate.

Partial Provisional audit: The service has a recruitment plan in place focussing on the provision of registered nurses to be on site 24 hours. The service has a plan to address educational needs for increased level of care including the orientation programme. The service is required to ensure that newly appointed staff (RNs) have appropriate orientation/induction, fire safety training and medication education including competency prior to occupancy of hospital care residents.

### Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by either the nurse manager or the registered nurse who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Improvements are required whereby assessment reviews and long term care plan evaluations are conducted within the expected timeframes. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required whereby all required assessments are conducted for identified care issues. Short term care plans are utilised. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training and competency is assessed annually. Resident medications are reviewed by the residents’ general practitioner at least three monthly. Self-medicating residents are appropriately supported to do so. A range of activities are available in the rest home and residents provide feedback on the programme. Albany House has food policies and procedures for food services and menu planning appropriate for this type of service. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff complete food safety training.

### Safe and Appropriate Environment

Albany House displays a current building warrant of fitness which expires on 3 June 2015. Maintenance is carried out. Chemicals are stored in a locked cleaning cupboard and hot water temperatures are monitored and recorded. Improvements are required whereby electrical equipment is tested and tagged and medical equipment is calibrated by an authorised technician. Residents’ rooms are of 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. There is a lounge and dining area, and small 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. There is a designated laundry which includes storage of cleaning and laundry chemicals. 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, seating and shade provided. Smoking is only permitted in designated external areas. Appropriate training, information and equipment for responding to emergencies are provided. There is an improvement required around ensuring there is staff member on duty at all times with a current first aid certificate. There is an approved evacuation scheme and emergency supplies for at least seven days. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Partial Provisional audit: The service has purchased a sling hoist. Each resident room and hallways are of sufficient size to manoeuvre equipment such as hoists and wheelchairs. Communal bathrooms and toilets are also of sufficient size for the use of equipment. Improvement is required whereby chair scales are provided for use with non-ambulatory residents. There are two electric beds and the remainder are high low beds which can be manually raised and lowered.

### Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint and two with enablers, one with bedrails and one with a table. Improvements are required around care planning and monitoring of the enablers. Staff attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

### Infection Prevention and Control

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

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Albany Rest Home 2004 Limited |
| **Certificate name:** | Albany Rest Home 2004 Limited |

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

|  |  |
| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Albany House |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 28 July 2014 | **End date:** | 28 July 2014 |

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

The service has formally made an application to the DHB and MOH for 20 beds to be considered for dual purpose (rest home and hospital level care).

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 18 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 9 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 9 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 18 | Total audit hours off site | 11 | Total audit hours | 29 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 17 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | 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 Tuesday, 2 September 2014

## **Executive Summary of Audit**

**General Overview**

Albany Rest Home is a privately owned rest home in Gore. One owner is the nurse manager and the other owner provides maintenance and financial management support. The owners purchased Albany in February 2004 and have implemented a business plan and a quality plan for 2014. The nurse manager is supported by a part time registered nurse and care staff. The service provides rest home level care for up to 25 residents with 18 residents accommodated on the day of audit. Staff turnover is reported as low. The quality and risk management programme is managed by the nurse manager and registered nurse and involves the resident on admission to the service. Staff interviewed and documentation reviewed identifies 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 documenting communication with families, obtaining informed consent, providing mandatory education, training for the infection prevention and control coordinator, ensuring senior staff have a current first aid certificate, ensuring time frames are adhered to for residents risk assessments and care plan evaluations, ensuring risk assessments are completed for identified resident needs, monitoring of enablers and calibration of medical equipment.

Partial Provisional audit: The service has applied for 20 beds to be considered for dual purpose beds for rest home or hospital level care. Improvements are required whereby chair scales are provided for the use of non-ambulatory residents and newly appointed staff to receive orientation/induction and medication competencies prior to occupancy of hospital level care residents.

**Outcome 1.1: Consumer Rights**

The support provided to residents at Albany Rest Home is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. There is an improvement required around obtaining informed consent from residents in regards to being part of social media. There is documentation to evidence communication with families however there are improvements required around contacting families following resident’s incidents. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Advanced directives are appropriately recorded. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

**Outcome 1.2: Organisational Management**

Albany Rest Home has an organisational philosophy, which includes a vision, mission statement and strategic objectives.
The owners have owned the facility since February 2004. The nurse manager/owner is supported in her role by one other owner, a part time registered nurse and care staff. The facility is guided by a comprehensive set of policies and procedures. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. There are improvements required around providing education for staff including abuse and neglect, cultural safety, wound care and safe handling of chemicals. Staffing levels are safe and appropriate.

Partial Provisional audit: The service has a recruitment plan in place focussing on the provision of registered nurses to be on site 24 hours. The service has a plan to address educational needs for increased level of care including the orientation programme. The service is required to ensure that newly appointed staff registered nurses (RNs) have appropriate orientation/induction, fire safety training and medication education including competency prior to occupancy of hospital care residents.

**Outcome 1.3: Continuum of Service Delivery**

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by either the nurse manager or the registered nurse who also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Improvements are required whereby assessment reviews and long term care plan evaluations are conducted within the expected timeframes. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required whereby all required assessments are conducted for identified care issues. Short term care plans are utilised. The medication management system includes policy and procedures that follows recognised standards. Staff responsible for medication administration receive training and competency is assessed annually. Resident medications are reviewed by the residents’ general practitioner at least three monthly. Self-medicating residents are appropriately supported to do so. A range of activities are available in the rest home and residents provide feedback on the programme. Albany House has food policies and procedures for food services and menu planning appropriate for this type of service. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff complete food safety training.

**Outcome 1.4: Safe and Appropriate Environment**

Albany House displays a current building warrant of fitness which expires on 3 June 2015. Maintenance is carried out. Chemicals are stored in a locked cleaning cupboard and hot water temperatures are monitored and recorded. Improvements are required whereby electrical equipment is tested and tagged and medical equipment is calibrated by an authorised technician. Residents’ rooms are of 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. There is a lounge and dining area, and small 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. There is a designated laundry which includes storage of cleaning and laundry chemicals. 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, seating and shade provided. Smoking is only permitted in designated external areas. Appropriate training, information and equipment for responding to emergencies are provided. There is an improvement required around ensuring there is staff member on duty at all times with a current first aid certificate. There is an approved evacuation scheme and emergency supplies for at least seven days. Appropriate policies are available along with product safety charts. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Partial Provisional audit: The service has purchased a sling hoist. Each resident room and hallways are of sufficient size to manoeuvre equipment such as hoists and wheelchairs. Communal bathrooms and toilets are also of sufficient size for the use of equipment. Improvement is required whereby chair scales are provided for use with non-ambulatory residents. There are two electric beds and the remainder are high low beds which can be manually raised and lowered.

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

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there were no residents assessed as requiring restraint and two with enablers, one with bedrails and one with a table. Improvements are required around care planning and monitoring of the enablers. Staff attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

**Outcome 3: Infection Prevention and Control**

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

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 36 | 0 | 7 | 2 | 0 | 0 |
| **Criteria** | 0 | 82 | 0 | 10 | 1 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Seven of eight incident reports reviewed and associated resident files, did not show evidence of documented family notification. | Ensure that family are notified of resident’s incidents and that this is documented. | 90 |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.4 | The service is able to demonstrate that written consent is obtained where required. | PA Moderate | Advised by the nurse manager that the service has set up a social media page (Facebook) which clearly shows residents participating in activities and social occasions. Resident’s names are also included in some of the photos displayed on the site. Residents have been informed of the Albany House Facebook page and have verbally agreed to their involvement, however, signed informed consent has not been obtained for this activity. | Ensure that documented informed consent is obtained from individual residents, where photos or personal information is displayed in a public forum. | 30 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The service has not yet appointed appropriate service providers (including registered nurses to cover 24/7) to safely meet the needs of residents requiring a higher level of care (hospital level care) | To ensure appropriate service providers are employed to safely meet the needs of residents requiring hospital level care. | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | New staff have not yet been appointed and therefore the delivery of the orientation/induction programme is not evidenced.  | Ensure that newly appointed staff receive an orientation/induction programme that covers the essential components of the service prior to occupancy including medication competency and fire safety. | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The service has not provided training on abuse and neglect, cultural safety, wound care and safe handling of chemicals which are mandatory requirements.  | Ensure that all mandatory education is provided for staff. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | 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. | PA Low | Two of four permanent resident’s files reviewed evidenced that risk assessment reviews and long term care plan evaluations have been completed outside the required time frames. One was reviewed after 10 months and one was reviewed after 11 months. | Ensure timeframes are adhered to in relation to conducting risk assessment reviews and conducting long term care plan evaluations.  | 90 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment  | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Four of five resident files reviewed did not evidence that risk assessments have been conducted for identified issues. Assessments are required for two residents with nutrition and pain issues, one resident with continence and nutrition issues, and one respite resident with falls risk. | Ensure that all residents have appropriate risk assessments conducted to serve the basis of the care delivery plan. | 90 |
| 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 |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | A) medical/nursing equipment including blood pressure machine, stand on scales and thermometer has not been checked or calibrated; b) the service does not have scales available for use with non-ambulant residents.  | a) Ensure all medical equipment is checked and calibrated by an authorised technician annually (90 days); b) ensure the provision of scales suitable for weighing non-ambulatory residents (prior to occupancy of hospital level residents). | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems  | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The service does not ensure that all shifts have a trained first-aider. | Ensure that there is always a staff member on duty who has a current first aid certificate. | 90 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised.  | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | The long term care plan for one resident with an enabler (bed rails) does not reference the enabler and monitoring is not recorded. | Ensure that all enablers are recorded appropriately to guide staff in the safe use including monitoring. | 90 |
| HDS(IPC)S.2008 | Standard 3.2: Implementing the infection control programme | There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 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. | PA Low | The registered nurse has not attended recent infection prevention and control training to maintain best practice.  | Ensure that the infection prevention and control nurse attends training to maintain best practice. | 90 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (two care workers, one activities coordinator, one registered nurse, one nurse manager /owner) confirm their familiarity with the Code. Interviews with seven residents and three relatives confirm the services being provided are in line with the code of rights.
Code of rights and advocacy training is provided during new staff orientation and as a regular in-service education and training topic provided in June 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with seven residents and three relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints for residents and relatives. Residents meetings are held three times a year (minutes sighted for April 2014) providing the opportunity to raise concerns in a group setting. The most recent annual satisfaction survey (April 2014) includes the question relating to privacy, dignity and rights with 100% of the respondents replying they are either satisfied or very satisfied.
Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.
D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner information.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.
Discussions with seven residents and three relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.
D3.1b, d, f, i: The service has a philosophy that promotes independence, encourages a high level of wellness by maintaining a caring and stimulating environment, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4: there are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents’ files.
Church services are held during the week and also on Sundays. Contact details of spiritual/religious advisors are available to staff. All seven residents and three relatives confirm the service is respectful.
A resident satisfaction survey is carried out annually to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents and families are 100% satisfied or very satisfied.
D4.1a: Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family.
The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with seven residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Five care plans reviewed identify specific individual likes and dislikes. Two married couples reside at the service. Both of these couples have comprehensive documentation in their respective care plans around the need for staff to respect their privacy and time together.
The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect is a mandatory requirement and has not been provided in the last two years (# link 1.2.7.5).
Discussions with the nurse manager/owner and registered nurse report there have been no identified incidents of abuse or neglect.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.
There were no Maori residents living at the facility at the time of the audit.

D20.1: The service utilises a local Maori representatives on an as-needed basis for consultation. These contacts (Hokonui Ruanaga) are identified in policy.
Interviews with two care workers, one registered nurse and the nurse manager confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.
A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that are received. The nurse manager and registered nurse are in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. There are staff meetings every six weeks and four monthly resident meetings.
Seven residents and three relatives interviewed spoke very positively about the care and support provided. Two care workers, one registered nurse, one activities coordinator, and the nurse manager/owner have a sound understanding of principles of aged care.
A2.2: Services are provided at Albany Rest Home that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.
D1.3: All approved service standards are adhered to.
D17.7c: There are implemented competencies for care workers and registered nurses (medication competencies). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policies are in place relating to open disclosure. Seven residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.
Three relatives interviewed confirm they are notified of any changes in their family member’s health status, however sample of incident reports reviewed and associated resident files, evidence one in eight recording of family notification. This is an area requiring improvement. The nurse manager and registered nurse can identify the processes that are in place to support family being kept informed.
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.
D16.1b.ii the residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.
D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Policies are in place relating to open disclosure. Seven residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures. Three relatives interviewed confirm they are notified of any changes in their family member’s health status. The nurse manager and registered nurse can identify the processes that are in place to support family being kept informed.

**Finding:**

Seven of eight incident reports reviewed and associated resident files, did not show evidence of documented family notification.

**Corrective Action:**

Ensure that family are notified of resident’s incidents and that this is documented.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Albany house has policies and procedures relating to informed consent and advanced directives. A review of five files identified that five of five files included informed consent collected for photos for health care purposes, health information and outings as part of the admission process and agreement. Advised by the nurse manager that the service has set up a social media page (Facebook) which clearly shows residents participating in activities and social occasions. Resident’s names are also included in some of the photos displayed on the site. Residents been informed of the setting up of the Facebook page and have verbally agreed to their involvement, however, signed informed consent has not been obtained for this activity. Improvements are required in this area.
There is a resuscitation form and process. Resuscitation documentation is completed for the five resident files reviewed.
Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with three family 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:** PA Moderate

**Evidence:**

Albany house has policies and procedures relating to informed consent and advanced directives. A review of five files identified that five of five files included informed consent collected for photos for health care purposes, health information and outings as part of the admission process and agreement.

**Finding:**

Advised by the nurse manager that the service has set up a social media page (Facebook) which clearly shows residents participating in activities and social occasions. Resident’s names are also included in some of the photos displayed on the site. Residents have been informed of the Albany House Facebook page and have verbally agreed to their involvement, however, signed informed consent has not been obtained for this activity.

**Corrective Action:**

Ensure that documented informed consent is obtained from individual residents, where photos or personal information is displayed in a public forum.

**Timeframe (days):** 30 *(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:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The client information pack informs visiting can occur at any reasonable time. Interviews with seven residents and three relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident’s life are documented in the care plans.
D3.1.e: Discussions with seven residents and three relatives verify that they are supported and encouraged to remain involved in the community. Albany Rest Home support on-going access to community services (e.g. church, general practitioner visits, clubs, community library and family outings). Entertainers are invited to perform at the facility.
D3.1h: Discussions with three families verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.
Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service.
Interviews with seven residents and three relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.
The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been eight verbal complaints from three residents as sighted on the complaints register. There have been no written complaints for the past two years. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at management meetings and staff meetings.
D13.3h: A complaints procedure is provided to residents within the information pack at entry.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Albany Rest Home provides rest home level care for up to 25 residents with 18 residents accommodated on the day of audit. There are clearly defined and measurable goals developed for the strategic plan and quality and risk management plan. The mission statement sets out the vision and values of the service: “To provide a quality, homely environment in which the frail elderly and/or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed”. The mission statement is included in the information, which is given to each resident and family on admission.

An organisational chart visually describes reporting relationships for the ownership and management structure. The service has a business plan and a quality and risk management plan for 2014. The business plan includes goals relating to financial management, occupancy, staff retention and recruitment and building repairs and maintenance. The quality and risk management plan includes a focus on resident care, provision of effective programmes, meeting certification and contractual requirements, risk management and continuous improvement. Quality indicators are documented. Further specific quality initiatives includes full review of policies and procedures, making improvements to the service (to accommodate hospital level care residents), improving residents urinary and faecal continence, staff educational needs and improving residents access to specialist services. Dates for completion are documented with evidence of ongoing monitoring. The internal audit programme regularly assesses service performance.

The facility is privately owned with one owner in the role of nurse manager and one owner providing maintenance accounting support. The owners purchased the facility in February 2004. The nurse manager is an experienced registered nurse having worked in a variety of nursing roles. The service also employs a registered nurse who works in excess of eight hours per week. The registered nurse is experienced in aged care, with previous roles in management and quality and education. The owner/nurse manager, registered nurse and care staff have a sound understanding of aged care. The nurse manager has attended professional development in the past year relating to managing a rest home including attending regular managers meetings with other providers and DHB representatives, self-directed learning (managing workplace issues), regular supervision (mentor support), and clinical manager’s seminar April 2014, and medication competency May 2014. The nurse manager is in the process of completing the InterRAI training.

Partial Provisional audit: The service has applied to the MOH and DHB for consideration of additional services (20 dual purpose beds to serve rest home and hospital level care residents). The service has a governing body that meets the requirements for the needs of the service and the manager is suitably qualified to be responsible for the provision of services proposed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the nurse manager’s absence (owners absence), the registered nurse is in charge. The nurse manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the other owner and the registered nurse. Formal management meetings are held six weekly between the nurse manager, owner and registered nurse with discussion around occupancy, resident issues, and staffing.
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.

Partial Provisional audit: The service has applied to the MOH and DHB for consideration of additional services (20 dual purpose beds to serve rest home and hospital level care residents). The service meets the requirements for additional services to ensure that the day-to-day operation is managed effectively, timely, appropriately and safely.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The quality and risk management system is understood and implemented by the nurse manager, owner and staff.
A comprehensive set of policies and procedures are in place. The nurse manager reports that new and/or revised policies are developed with input from staff. The nurse manager signs off on all new policies. They are available for staff to read and to sign after reading.
Policies and procedures are stored in hard copy at the facility. An external provider provides updates and reviews, with the nurse manager conducting further reviews to ensure that each policy aligns with the service. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed annually unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.

Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan and current quality and risk management plan for 2014. The business plan includes goals relating to financial management, occupancy, staff retention and recruitment and building repairs and maintenance. The quality and risk management plan includes a focus on resident care, provision of effective programmes, meeting certification and contractual requirements, risk management and continuous improvement. The quality statement documents “our mission to offer care of a standard that shall ensure our customer satisfaction by exceeding their expectation of quality”. Quality indicators are documented for orientation of new residents and families, code of rights implementation, ensuring privacy and dignity, individual residents care plans and this link to the internal audit schedule. Further specific quality initiatives includes full review of policies and procedures, making improvements to the service (to accommodate hospital level care residents), improving residents urinary and faecal continence, staff educational needs and improving residents access to specialist services. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance. The resident/relative survey conducted in April 2014 attracted 10 respondents. Comments were very positive with residents stating they were over all very satisfied. Survey outcomes are to be communicated to residents via the August 2014 resident meeting. Discussions with individual residents also occurred to address any issues that were identified via the survey process. Residents/families were surveyed around privacy and dignity, medical services, care assistance, cleaning, food services, activities, laundry services, safety and security and gardening. Management meetings (two owners and the registered nurse) are held every six weeks and the last one was held 18 June 2014. General staff meetings are held every six weeks (minutes sighted for 16 July 2014) with standing agenda items including incident and accident reporting, infection control, complaints and compliments, restraint, health and safety, internal audits, in-service education, policies and procedures review and service objectives. Resident and family meetings are held three times a year, minutes sighted for April 2014. Discussion is held at residents meetings around food, activities, concerns or complaints, personal cares, and laundry with minutes posted on the resident notice board.

The internal audit programme involves monitoring areas of quality and risk including complaints management, infection prevention and control, health and safety, and restraint minimisation. Various aspects of the service are regularly monitored with examples including resident and family satisfaction surveys (annually), care plan audits (annually), medication (annual), cleaning (six monthly), laundry (annually), activities programme (annually), food service (annually), safety (annually) and resident admission procedure (annually). A process to measure achievement against the quality and risk management plan is in place. The quality continual improvement policy objective documents “all sub-optimal services will be promptly investigated and trends analysed with a planned course of corrective action. The nurse manager is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurse and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule.

Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are put into place where opportunities for improvements are identified. Results of the internal audits are discussed in the six weekly staff meetings, and six weekly management meetings.
The nurse manager oversees all quality initiatives with support from the other owner.
Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).

D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.
D19.3: there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management
D19.2g: Falls prevention strategies include sensor mats and closely observing residents who are at risk of falling, use of mobility aids, correct footwear and exercise and walking groups.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.
Adverse events (including but not limited to: falls, skin tears, bruising, challenging behaviours, medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted).
Eight incident forms were reviewed for June and July 2014 relating to three residents. Incident reports reviewed included two falls and six behavioural issues (behavioural management plans in place). Contact with family is evidenced on one incident report reviewed (# link 1.1.9.1). Adverse events include an investigation. Follow up is conducted by the registered nurse and GP is notified if required. Either the registered nurse or nurse manager investigates all events with further follow up by the nurse manager if required. The adverse events form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. Annual collation and analysis of reports is conducted.
Statutory and regulatory obligations are understood by the nurse manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are 17 staff employed by Albany Rest Home which includes a registered nurse, care workers, housekeeping and kitchen staff and activities person. Housekeeping and kitchen staff also undertaking care giving duties. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurses. Practising certificates were also sighted for general practitioners.
Five staff files were randomly selected for review (one registered nurse, one cook, one activities co-ordinator and two care workers). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency. Not all staff (with senior responsibility) has a current first aid certificate (# link 1.4.7.1). Staff undergo initial and annual performance appraisals, evident in four of five staff files. One staff member file reviewed commenced employment in the past four months.

Albany Rest Home has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed care workers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently. Interviews with two care workers confirm their orientation to the service was thorough. All five staff files reviewed reflected evidence of an orientation programme that had been completed.
Discussion with the registered nurse and care workers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.

Care workers have completed either the national certificate in care of the elderly or are working towards completion. The registered nurse is a certified trainer and assessor for the career force programme which all caregivers have commenced, including those with previous caregiving qualifications.
A system is in place to identify, plan, facilitate and record on-going education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. The education and training plan for 2014/2013 included the following: medication management, falls prevention, continence, dementia and challenging behaviours, restraint minimisation, health and safety and infection control. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions. The service has not provided training on abuse and neglect, cultural safety, wound care and safe handling of chemicals in the past two years which are mandatory requirements. This is an area requiring improvement.

The nurse manager has attended InterRAI training.
Registered nurses and caregiver competencies available include medication administration knowledge and observed practice, insulin, and controlled drug administration. A tracking process is in place to ensure those who administer medications complete their annual medication competencies.

Partial Provisional: The service has a documented plan for employing additional staff (registered nurses and care workers) to accommodate hospital level care residents (dual purpose beds). Newly appointed staff are required to complete the induction programme, orientation (including fire drill) and competencies such as medication. This is an area that could not be evidenced on the day of the audit as new staff have not yet been appointed. This is an area requiring improvement prior to accepting residents for hospital level care. The service has a documented plan to focus on education for increased clinical care needs such as training on peg feeds and syringe drivers.

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

**Evidence:**

There is 17 staff employed by Albany Rest Home which includes a registered nurse, care workers, housekeeping and kitchen staff and activities person. Housekeeping and kitchen staff also undertaking care giving duties. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurses. Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency.

**Finding:**

The service has not yet appointed appropriate service providers (including registered nurses to cover 24/7) to safely meet the needs of residents requiring a higher level of care (hospital level care)

**Corrective Action:**

To ensure appropriate service providers are employed to safely meet the needs of residents requiring hospital level care.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Albany Rest Home has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed care workers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently

**Finding:**

New staff have not yet been appointed and therefore the delivery of the orientation/induction programme is not evidenced.

**Corrective Action:**

Ensure that newly appointed staff receive an orientation/induction programme that covers the essential components of the service prior to occupancy including medication competency and fire safety.

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.

Care workers have completed either the national certificate in care of the elderly or are working towards completion. The registered nurse is a certified trainer and assessor for the career force programme which all care givers have commenced, including those with previous caregiving qualifications.

A system is in place to identify, plan, facilitate and record on-going education for staff. The education and training plan for 2014/ 2013 included the following: medication management falls prevention, continence, dementia and challenging behaviours, restraint minimisation, health and safety and infection control. Education is provided either as face to face sessions, self-directed reading and learning or attendance at off-site sessions

**Finding:**

The service has not provided training on abuse and neglect, cultural safety, wound care and safe handling of chemicals which are mandatory requirements.

**Corrective Action:**

Ensure that all mandatory education is provided for staff.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A good employer policy is in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time and casual staff fill casual shifts and no agency staff are available. The nurse manager works fulltime. The registered nurse works in excess of eight hours per week and shares after hour’s on-call with the owner/nurse manager as required. The nurse manager and other owner are available after hours for clinical and non-clinical service issues. There is further support from general practitioners, and St Johns ambulance service if required. Care staff interviewed advised that they are well supported by owners including the nurse manager and the registered nurse. Roster includes two care workers on the morning shift who work 7am – 3pm (three care workers work on the morning shift Saturday and Sunday). Two care workers work 3pm – 11pm. There is one caregiver on overnight from 11pm – 7am. There are two cooks employed daily, one for the morning and one for tea time. Activities are provided by an activities coordinator in the afternoon.
Staff turnover is reported by the owner/ nurse manager as low. Staffing levels are altered according to resident numbers and acuity.
One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.
Seven residents and three relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

Partial Provisional audit: The service has a draft roster (as sighted) to ensure safe staffing for proposed hospital level care including a registered nurse on every shift and increasing care workers with increments of five hospital level residents (up to 20) admitted to the service.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse’s station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
D7.1 entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.
Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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. Three family members and seven residents 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 five resident files sampled. 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 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/whanau. 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:** PA Low

**Evidence:**

There is a policy and process that describe resident’s admission and assessment procedures. Either the nurse manager or the registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission. The long term care plan is developed within three weeks of admission as evidenced in four of five files reviewed (one respite resident). In all permanent resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Improvements are required whereby timeframes are adhered to in relation to conducting assessment reviews and conducting long term care plan evaluations. Six monthly reviews have been conducted, or earlier if resident health changes, for two of four permanent residents. Two of four have been completed outside the required time frames. These have been completed by the nurse manager or registered nurse with input from the care staff, the activities coordinator and any other relevant person. Activities assessments and care plans are developed by the activities coordinator. Handover occurs at the end of each duty that maintains a continuity of service delivery. There is a communication book which staff read that includes reviewed policies. The nurse manager and registered nurse share on-call and after hours and weekend cover.
Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of four permanent resident files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. GP interviewed stated that the service contacted him in a timely fashion, providing him with information required to assess his residents. The service always carried out any observations and interventions he prescribed.
There is a comprehensive assessment document and risk assessment tools available for use on admission and as required thereafter, including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment and e) pain assessment. All five files recorded that an assessment of care requirements have been conducted on admission. Further risk assessments have not been completed for all identified issues for the four permanent residents as per finding #1.3.4.2. The InterRAI assessment tool has not yet been implemented. Advised that the nurse manager is in the process of completing the InterRAI training. Long term care plans reviewed for four permanent residents’ evidence comprehensive and resident focused goals and interventions. All four files identified integration of allied health including podiatry. The respite resident has a short term care plan in place which was developed on admission.

Five resident files sampled are as follows: one respite resident, one resident with insulin dependent diabetes, one resident with anxiety related behaviours, one resident with increasing care needs and an enabler, and one resident with a chronic wound and recent acute care admission.

Tracer Methodology:

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:** PA Low

**Evidence:**

Either the nurse manager or the registered nurse undertakes the assessments on admission. An initial nursing assessment and short term care plan is completed within 24 hours of admission as evidenced in five of five resident files reviewed. The long term care plan is developed within three weeks of admission as evidenced in four of five files reviewed (one respite resident). In all permanent resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Six monthly reviews have been conducted, or earlier if resident health changes, for two of four permanent residents.

**Finding:**

Two of four permanent resident’s files reviewed evidenced that risk assessment reviews and long term care plan evaluations have been completed outside the required time frames. One was reviewed after 10 months and one was reviewed after 11 months.

**Corrective Action:**

Ensure timeframes are adhered to in relation to conducting risk assessment reviews and conducting long term care plan evaluations.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A nursing assessment is completed within 24 hours of admission. The nursing assessment includes: activity level, orientation, sleep, mobility, nutrition, elimination, perception, mental ability, social history, personal ability and independence, skin integrity, sexuality/privacy, values and beliefs. Personal needs, outcomes and goals of residents are identified. There is a range of risk assessment tools available for completion on admission and to be reviewed at care plan review (link finding #1.3.3.3) six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment. Assessments are conducted in an appropriate and private manner. One of five files reviewed evidenced that assessments are conducted for all identified needs. Improvements are required in this area. All seven residents interviewed are satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Seven resident interviews and three family members 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 such as (but not limited to): elimination, sensory, social behaviours, mobility and exercise, skin, hygiene and grooming, nutrition and hydration, sleep, cultural and spiritual. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.
The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

A nursing assessment is completed within 24 hours of admission. The nursing assessment includes: activity level, orientation, sleep, mobility, nutrition, elimination, perception, mental ability, social history, personal ability and independence, skin integrity, sexuality/privacy, values and beliefs. Personal needs, outcomes and goals of residents are identified. There is a range of risk assessment tools available for completion on admission and to be reviewed at care plan review (link finding #1.3.3.1) six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment. Assessments are conducted in an appropriate and private manner. One of five files reviewed evidenced that assessments are conducted for all identified needs. Pressure risk assessments are completed for all five residents reviewed.

**Finding:**

Four of five resident files reviewed did not evidence that risk assessments have been conducted for identified issues. Assessments are required for two residents with nutrition and pain issues, one resident with continence and nutrition issues, and one respite resident with falls risk.

**Corrective Action:**

Ensure that all residents have appropriate risk assessments conducted to serve the basis of the care delivery plan.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents' files include where appropriate: resident information and admission information, initial nursing assessment and risk assessments, pain management plans, long term care plans, short term care plans, wound care plans, multidisciplinary progress notes, doctors notes, resuscitation and informed consent documents, activities assessment, care plans and progress notes, laboratory reports, letters and communications, and needs assessment information. The initial short term care plan is developed from the initial assessment and identifies the areas of concern or risk. Resident comprehensive long term care plans are individually developed with the resident and family/whānau. Seven residents and three family members interviewed stated they are involved in the care planning process. Four permanent resident comprehensive long term care plans reviewed were evidenced to be up to date. Nursing diagnosis, goals and outcomes 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): elimination, sensory, social behaviours, mobility and exercise, skin, hygiene and grooming, nutrition and hydration, sleep, cultural and spiritual. Each aspect of the care plan includes goals, interventions and assistance required and evaluations.
There is evidence that residents are seen by the GP at least three monthly. Notes are well maintained.
Short term care plans are in use for changes in health status and are recorded on a problem page. Examples sighted are cares required for wounds, continence, angina, behaviours, infections and return from acute care. Five resident files reviewed identified 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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Albany House provides services for residents requiring rest home level of care. Individualized care plans are completed. The two care workers and registered nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.
Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment (these require calibration link #1.4.2.1)
There is currently one wound being treated, one resident with a previous wound who is being monitored and no pressure injuries. Wound assessment and management plan is completed for the wound and there was evidence of referral to district nursing services and wound care specialist. Wound care education has not been provided in the past two years (link finding #1.2.7.5).
Seven residents and three family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.
Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed.
All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission for four permanent residents – one respite resident did not have a falls risk assessment completed (link #1.3.4.2). Reviewing of risk assessments has not been conducted for three of five files reviewed (link finding #1.3.3.3). A physiotherapist referral can be initiated as required.
There is one part time registered nurse employed by the service and the owner/manager is a registered nurse. A record of all health practitioners practicing certificates is kept.
Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals (with exceptions #1.3.3.3). Care plans are updated to reflect intervention changes following review or change in health status. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.

##### **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 Albany House who is responsible for the planning and delivery of the activities programme. The activities coordinator works five afternoons per week for two hours per day. The activities coordinator is relatively new to the aged care industry and has been in the role since March 2014. She attends meetings and peer review with other local rest home activity coordinators. Activities are provided in the lounge, dining area, gardens (when weather permits) and one on one input in resident’s rooms when required. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly and a daily copy of the programme is available in the lounge. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events.
The programme includes residents being involved within the community with social clubs, churches and schools. The social profile forms the basis of the motivational therapy plan for each individual resident and includes goals, plans, and interests. A record is kept of individual resident’s activities and monthly progress notes are completed. The resident/family/EPOA as appropriate is involved in the development of the motivational therapy plan. There is a wide range of activities offered that reflect the resident needs including housie, bowls, music and entertainment, church services, quizzes and games, craft, reminiscing, exercises and van outings.. Participation in all activities is voluntary.
Albany House has its own van for transportation which has a current registration and warrant of fitness. Residents interviewed advised that they find the activities programme enjoyable and that the activities coordinator provides an interesting and stimulating programme. The activities coordinator does not have a current first aid certificate (link #1.4.7.1).
D16.5d: Resident files reviewed identified that the individual activity plan is reviewed monthly.

##### **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 a registered nurse on day of admission and resident comprehensive long term care plans developed within three weeks of admission. Long term care plans are evaluated six monthly or if there is a change in health status for two of four permanent resident files reviewed (link 1.3.3.3).

Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents. Short term care plans are in use for changes in health status and are recorded on a problem page. Examples sighted are cares required for wounds, continence, angina, behaviours, infections and return from acute care.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. The manager and registered nurse interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted.
Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.
There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.

##### **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 a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.
The service has in place 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 GP. Albany House uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents’ general practitioners; these are kept in the medication folders. The medication folder includes a list of specimen signatures. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications.

The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management occurred in July 2013 and competencies are conducted for senior care workers with medication administration responsibilities. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication. The service has adequate information and supervises the self-administration of medicines. There are no resident’s currently self- administrating medications.

The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents’ medication charts and resident files on the front page. There is a staff signature identification sheet in the front of the medication folders. Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Medications were safely stored in a medication trolley which is kept in a locked cupboard when not in use. All medications were up to date and eye drops were dated on opening. There are no residents currently prescribed regular controlled drugs. The controlled drug register showed evidence of previous weekly and six monthly checks. The register showed evidence of two when signing out controlled drugs. One staff member was observed safely administration medications at the lunch time medication round.

Partial Provisional audit: the service has systems and processes in place to adequately meet the medication requirements of hospital level residents. Advised that when further registered nurses are employed, they will receive an orientation, education and competency assessment in relation to medication management (link #1.2.7.5).

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Albany House has an appropriate sized kitchen and all food is cooked on site. There are two cooks and two tea assistants. Both cooks have food completed 167 and 168 food safety training unit standards. There is a four weekly rotating winter and summer menu. A food safety audit and menu review was recently conducted by a registered dietitian (July 2014). 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. All food is served hot directly from the oven and oven top from food preparation containers to residents in the dining room or to their rooms as required. All food in the freezer and fridge is labelled or 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 (with exceptions #1.3.4.2). Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook interviewed. Forms from the registered nurse to the cook were sighted for residents requiring fortified diets. Each resident has a dietary profile completed on admission. Special diets are noted in a file in the kitchen, which can be viewed only by kitchen staff. Special diets being catered for include pureed diets and soft diets. Weights are recorded weekly/monthly as directed by the registered nurses. Residents report satisfaction with food choices, and meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

Partial Provisional: the service has adequate supplies of plates and cutlery including lipped plates and cutlery with modified handles. The service has the ability to modify the texture of meals and has information and resources on file for special dietary needs. A speech language therapist and dietitian are available via referral process as required. Advised that extra staff will be employed and rostered on to ensure that there are sufficient staff on duty to assist all resident with meals and drinks.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There 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. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked. Bulk chemicals are stored in a locked cleaner’s cupboard until required. Product use charts are available. Hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Interviews with two care workers and one house keeper described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff have not received education in chemical safety in the past two years (link #1.2.7.5).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service displays a current building warrant of fitness which expires on 3 June 2015. Hot water temperatures checks are conducted and recorded monthly by the owner/maintenance person. Hot water is provided via a gas hot water system which is set at 45 degrees for resident areas. Hot water temperature recordings reviewed for 2014 are consistently recorded between 41 and 45 degrees Celsius. The service has purchased a new sling hoist. The blood pressure machine, scales and thermometer has not been calibrated by an authorised technician and testing and tagging has not been conducted on electrical equipment. Improvements are required in these areas. The interior is well maintained with a home-like décor and furnishings. There is a large communal lounge, a smaller television lounge and a large dining area adjacent to the kitchen. There are eight communal toilets and six communal shower facilities. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. 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 two care workers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.

Partial provisional audit: The following equipment is available: two electric high low beds, the remainder are manual high low beds, reclining chairs, shower chairs, a new sling hoist, heel protectors, lifting aids. The service does not have scales available for weighing immobile residents. Improvements are required in this area. Resident rooms and hallways are of sufficient space to allow the use of mobility equipment and the sling hoist (verified), and for care staff to safely attend to resident needs.

##### **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 5 June 2014. Hot water temperatures checks are conducted and recorded monthly by the owner/maintenance person. Hot water temperatures are recorded and are consistently recorded between 41 and 45 degrees Celsius. The service has purchased a new sling hoist.

**Finding:**

A) medical/nursing equipment including blood pressure machine, stand on scales and thermometer has not been checked or calibrated; b) the service does not have scales available for use with non-ambulant residents.

**Corrective Action:**

a) Ensure all medical equipment is checked and calibrated by an authorised technician annually (90 days); b) ensure the provision of scales suitable for weighing non-ambulatory residents (prior to occupancy of hospital level residents).

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All resident rooms in the rest home have hand basin facilities with shared communal toilets and showers. The number of toilets and showers provided is adequate and includes six showers and eight toilets. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Seven residents 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 and in all resident rooms. 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 and include large vacant/in-use signs.

Partial provisional: all communal toilets and showers are of sufficient size to accommodate hospital level residents, care staff, a hoist and shower chairs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvred 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.

Partial provisional: the service has two electric high low beds and the remainder are manual high low beds. The resident rooms are of sufficient size to accommodate hospital level residents including lifting equipment and reclining chairs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a large lounge, a smaller television lounge and a large dining room. The dining room is spacious, 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 seven residents interviewed report they can move around the facility and staff assist them if required.

Partial provisional: all communal areas are of sufficient size to cater to hospital and rest home level residents including a spacious dining room where residents will be able to be assisted with their meals and drinks.

##### **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:**

Albany House 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 the care staff. Staff attend infection control education and there is appropriate protective clothing available. There is a designated cleaner and care staff complete laundry tasks. Manufacturer’s data safety charts are available. Seven residents and three family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Resident satisfaction survey conducted in April 2014 included questions around laundry with 100% satisfaction with the service. Laundry audit conducted in June 2014 and cleaning audit conducted in June 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:** PA Low

**Evidence:**

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. The service does not ensure that all shifts have a trained first-aider. This is an area requiring improvement. The New Zealand Fire Service approved the fire evacuation scheme on the 12 August 2004. Fire evacuation drills have occurred six monthly - last conducted on 16 April 2014. A civil defence emergency kit is readily available in each of the three corridors throughout the facility and there is sufficient water stored in case of emergency. Battery operated emergency lighting, extra torches and gas cooking and gas hot water and is in use/available. The service has a generator if required in an emergency. Fire alarms and hose reels are checked by a contracted company. Testing and tagging of electrical appliances has not been conducted (# link 1.4.2.1). Call bells are evident in resident’s rooms, dining and living areas, corridors and toilets/bathrooms. Security policies and procedures are in place. There is a procedure for additional resident supervision to maintain safety. The service has extra food and water available to last for at least seven days should the need arise. The service last held an emergency planning meeting on 7July 2014.

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

**Evidence:**

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. Fire evacuation drills have occurred six monthly- last conducted on 16 April 2014.

**Finding:**

The service does not ensure that all shifts have a trained first-aider.

**Corrective Action:**

Ensure that there is always a staff member on duty who has a current first aid certificate.

**Timeframe (days):** 90 *(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 and ventilated. Seven residents and three family interviewed state the environment is warm and comfortable. Heating is provided by large panel heaters and night store heaters. The facility was of a comfortable temperature on the day of audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** PA Low

**Evidence:**

Albany House has comprehensive policies and procedures on restraint minimisation and safe practice. The owner/nurse manager is the restraint coordinator and confirms that the service promotes a restraint-free environment.
Policy states that enablers are voluntary. There are two residents using enablers (one with bed rails and one with a locking table) and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.
Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. One resident file was reviewed (bed rails) and evidenced that an enabler assessment has been conducted and verbal consent has been obtained. The long term care plan does not reference the enabler and monitoring is not recorded. Improvements are required in this area. Restraint education last provided for staff in August 2013 with associated questionnaire and competency.

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

**Evidence:**

Policy states that enablers are voluntary. There are two residents using enablers (one with bed rails and one with a locking table) and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.
Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, a restraint plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. One resident file was reviewed (bed rails) and evidenced that an enabler assessment has been conducted and verbal consent has been obtained. Restraint education last provided for staff in August 2013 with associated questionnaire and competency.

**Finding:**

The long term care plan for one resident with an enabler (bed rails) does not reference the enabler and monitoring is not recorded.

**Corrective Action:**

Ensure that all enablers are recorded appropriately to guide staff in the safe use including monitoring.

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Albany Rest Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by an external provider and signed off by the nurse manager. The nurse manager is the service infection control coordinator. The management team and staff meeting incorporates the infection control committee. 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 (September 2013 and April 2014). Annual review of the 2013 programme was conducted in June 2014. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** PA Low

**Evidence:**

The nurse manager is the infection prevention and control (IPC) nurse. She is supported by the registered nurse and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The registered nurse has not attended recent infection prevention and control training to maintain best practice. This is an area requiring improvement. The IC nurse and staff have good external support from the local laboratory infection control team and IC nurse expert at Southern DHB. The infection control team is representative of the facility.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The nurse manager is the infection prevention and control (IPC) nurse. She is supported by the registered nurse and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation.

**Finding:**

The registered nurse has not attended recent infection prevention and control training to maintain best practice.

**Corrective Action:**

Ensure that the infection prevention and control nurse attends training to maintain best practice.

**Timeframe (days):** 90 *(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 policies 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 by an external contractor and updated by the nurse manager and registered nurse to ensure best practice information is included. The policies and procedures were last updated and reviewed in June 2014. Albany Rest Home’s infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (RN). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in April 2014 in relation to hand washing and hand hygiene. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. There have been no outbreaks at the service over the last two years. Residents are informed of infection prevention matters that are appropriate to their needs and this is documented in medical records.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Infection surveillance is an integral part of the infection control programme and is described in Albany House’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 is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks at the service over the last two years.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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