# Aria Park Senior Living Limited

## Current Status: 28 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance 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

Aria Park provides care for up to 130 residents (including up to 46 in serviced apartments). During the audit there were 37 rest home residents and 41 hospital residents. Additionally, there is one hospital resident in the studio apartments and one rest home resident in the serviced apartment.

The facility manager was recently appointed to this role (May 2014) and is a registered nurse with a current annual practising certificate. She has over 20 years of experience in the health and disability sector in senior leadership and management roles. Family and residents interviewed all spoke positively about the care and support provided.

Five of eight shortfalls identified at the previous audit have been addressed. These are around quality data analysis, use of studios for hospital level, continuity of care and residents who self-administer medications. Improvement continues to be required around complaint documentation, progress notes, care planning, medication management and infection control surveillance.

This audit has identified further areas requiring improvement around meetings, incident reporting, assessments wound management, activities and activities plans, calibration of equipment and enabler use.

## 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 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 medium or high risk and/or unattained 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

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| --- | --- | --- |
| 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. |

# 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:** | Aria Park Senior Living Limited |
| **Certificate name:** | Aria Park Senior Living Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Aria Park Retirement Village | | | |
| **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:** | 29 July 2014 |

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

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

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 12 | **Hours off site** | 6 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 12 | **Total hours off site** | 6 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 10 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 72 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Thursday, 4 September 2014

## Executive Summary of Audit

**General Overview**

Aria Park can provide care for up to 130 residents (including up to 46 in serviced apartments). During the audit there were 37 rest home residents and 41 hospital residents. Additionally, there is one hospital resident in the studio apartments and one rest home resident in the serviced apartment. The Ministry of Health has granted special dispensation for the hospital resident to be cared for in a studio apartment in a letter dated 23 September 2013.

The facility manager has recently been appointed to this role (May 2014). She is a registered nurse with a current annual practising certificate. She has over 20 years of experience in the health and disability sector in senior leadership and management roles. Family and residents interviewed all spoke positively about the care and support provided.   
Five of eight shortfalls identified at the previous audit have been addressed.  These are around quality data analysis, use of studios for hospital level, continuity of care, residents who self-administer medications.  Improvement continues to be required around complaint documentation, progress notes, care planning, medication management and infection control surveillance.

This audit has identified further areas requiring improvement around meetings, incident reporting, assessments wound management, activities and activities plans, calibration of equipment and enabler use.

**Outcome 1.1: Consumer Rights**

There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies. Interpreter services are available if needed. Families of the resident’s report the manager and staff keep them informed of their family member’s status.   
There is a complaints policy supporting practice and a complaints register. Resident and family interviews confirmed their understanding of the complaints process. There have been no recent external complaints relating to the rest home or hospital. Improvements are required around notifying families of incidents and complaint management.

**Outcome 1.2: Organisational Management**

Aria Park has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.   
Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly. There are improvements required around aspects of the quality system including corrective action planning and incident reporting.

Aria Park has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme documented. There is improvement required around staff training. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

**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. Support plans are developed by the registered nurses who also have the responsibility for maintaining and reviewing support plans. Support plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents.

The medication management system includes Medication Policy and Procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available and residents provide feedback on the programme. The service has food policies/procedures for food services and menu planning appropriate for this type of service, dietitian input is obtained.

The service has addressed and monitored previous shortfalls relating to regular progress notes, turning charts, specialist input into wound care and self-medicating residents. Previous shortfalls around linking physiotherapist recommendations to care plans, the content of care plans to address the needs of the resident and transcribing of medications remain areas for improvement.

This audit identified further areas for improvement around; the use of formal assessment tools, the documentation of and evaluation of short term care plans, wound care plan documentation, medication management and the provision and documentation of activities.

**Outcome 1.4: Safe and Appropriate Environment**

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness. Electrical equipment is checked. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted and there are handrails. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas. There is an improvement required around calibration of medical equipment.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is an improvement required around enabler use.

**Outcome 3: Infection Prevention and Control**

The infection control coordinator is the clinical manager who is a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. There is an improvement required around including all infections in infection monitoring data.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 4 | 0 | 7 | 7 | 0 | 0 |
| **Criteria** | 0 | 29 | 0 | 7 | 8 | 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 | 32 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 57 |

## 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 | Two of nine incident forms sampled do not document that family were informed. There is no recorded in the corresponding progress notes of family being informed. One of these incidents is for a significant sum of money being found around the room of a resident who is not competent to care for the money. | Ensure family are informed of all incidents and that this is documented. | 90 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | One of the two complaints for 2014 does not show documented evidence of a resolution letter being sent to the complainant. | Ensure that all complaints are acknowledged, investigated and that the complainant is notified of the outcome and that this is documented. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | (I) Minutes have not been completed for the May, June and July 2014 quality meetings meaning it is difficult to follow issues through. (ii) Meeting minutes of staff meetings show other staff are not aware of the outcomes of quality data analysis. (iii) Restraint is not discussed at quality meetings for those meetings where minutes are available. | (i)Ensure quality meeting minutes are taken and made available and copies kept. (ii) Ensure all staff are informed of the outcomes of quality data analysis and trends. (iii) Ensure restraint is discussed in quality meetings or some other regular forum. | 90 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Where shortfalls are identified in the regular monthly audits there is no evidence of corrective action plans being developed. Some corrective action plans are developed when shortfalls are identified in other audits but there is no evidence of these having been implemented and signed off. | Ensure that corrective action plans are developed when service shortfalls are identified and that corrective action plans are implemented and signed off when completed. | 90 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | There were two skin tears noted in resident files where no incident form has been completed. | Ensure incident forms are completed for all incidents. | 90 |
| 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 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There has been no training around restraint use and the management of challenging behaviour. Attendance at trainings is low with less than 15 staff attending abuse and neglect, falls prevention and skin/pressure area risk management. | Ensure training is provided around restraint and challenging behaviour management and that staff training attendance is such that all staff receive essential trainings. | 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 | Physio interventions and recommendations were not documented in one care plan. Progress notes care interventions ‘ tick templates’ are not always completed ( one hospital file and one rest home file) | Ensure physio interventions and recommendations are documented in the care plans. Ensure progress notes care interventions ‘tick templates’ are completed daily. | 60 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate |  |  |  |
| 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 Moderate | In the four hospital level resident files reviewed; one has an incorrect nutritional needs form, and no pain assessment, one had an incomplete pain assessment, one had assessments that had not been reviewed six monthly. In the rest home one file has incomplete assessments, and one does not reflect the cultural status of the resident, and two files have incomplete assessments, and assessments not reviewed six monthly, weights are not documented as undertaken monthly in two resident files. Dietary needs forms have not been communicated to the kitchen for two resident files. | Ensure that all assessments are documented fully in a timely manner and dietary needs are communicated to the kitchen. | 30 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Of the three rest home resident files reviewed; one did not have any cultural care included for a resident of a different culture. In the hospital, of the four resident files reviewed; one with no interventions for pain where pain is an identified problem one with diet and feeding interventions not documented and two with no weight management where weight management is an identified problem, and one with pressure area care not well documented. | Ensure that all identified resident problems have interventions documented in the residents’ LTCP | 60 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | There are ten wounds in the rest home (including one pressure area). Wound care plans are in place for all identified wounds; however one has three skin tears on one wound form and the pressure sore does not state the grade.  Hospital upstairs has six identified wounds including one pressure sore. Wound care plans are documented well with the exception of the pressure which does not state the grade. Hospital downstairs has four identified wounds these four wound plans all have documentation problems including pain assessments not documented as per plan for two wounds, one has no initial assessment and one wound identified through the progress notes has no wound care plan (this wound is a pressure sore).  Wounds identified has no short term care plan in place. Short term care plans for other conditions such as UTI had not been reviewed and there was no short term care plan for a resident with diarrhoea. | Ensure STCPs are in place for short term of acute events. Ensure wound care plans are in place for all wounds, and that wound care plans and assessments describe the wound and the care needed. | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Two of three rest home level residents did not have a documented individualised activity plan for each resident. Two of four hospital level activity plans do not document six monthly reviews. A review of the activity plans for the service does not document community links and attendance sheets for activities do no document level of involvement. | Ensure all residents have an up to date individualised activity plan. Ensure that community links are maintained and attendance sheets record level of involvement with activities. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | In the rest home; there were four medication charts instances of regular medications not signed for, the use of ‘white out’ on a chart and one instance of transcribing. In the hospital there was one instance of medication not signed on administration. A resident who had BSLs prior to insulin has the BSL taken two hours prior to the insulin and results stored in a separate file. The medication fridge contained out of date XXXXX and XXXXX not dated on opening. During resident interviews it was also observed that medication had been left on a resident’s table for them. This medication had been signed as given. | Ensure that medications are signed when given, Transcribing must cease. Ensure medications are checked to ensure they are all in date and dated on opening as needed. BSLs prior to insulin should be taken close to the time of administration and the results easily available to the administrator. | 60 |
| 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 | Not all medical equipment has been calibrated. | Ensure all medical equipment is calibrated according to the manufacturer’s instructions. | 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 | A review of three files for residents with enablers demonstrates that they are referred to in the care plan as restraints and that the resident is unable to consent to the bedrail, meaning they are not voluntary and therefore are restraints. | Ensure the use of enablers is voluntary. | 90 |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 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. | PA Low | A review of resident files showed one upper respiratory tract infection and one wound infection that were not included in the infection monitoring data. This is an area requiring improvement. | Ensure all infections are included in the infection monitoring data. | 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 1.1.9: 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:**

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Nine incidents/accidents forms were viewed for July 2014. The form includes a section to record family notification. Seven of the nine forms reviewed indicated family were informed or if family did not wish to be informed. This is an area requiring improvement. Aria Park has an open disclosure policy. On interview ten residents (five rest home, five hospital), four family members (one rest home, three hospital) and seven caregivers all stated that family are informed following changes in the resident’s health status.  
The three registered nurses and the clinical manager interviewed stated that they record contact with family/whanau in resident’s files. Contact records were documented in all seven resident files reviewed.   
Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.  
A residents/relatives meeting occurs monthly and issues arising from the meeting are fed back to quality meetings. Issues raised generate an investigation and corrective actions are recorded on the meeting minutes.  
There is a policy that describes the availability of interpreter services when required.   
D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.  
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b: Four of four family members interviewed stated that they are always informed when their family members health status changes.  
D11.3: The information pack is available in large print and advised that this can be read to residents.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Nine incidents/accidents forms were viewed for July 2014. The forms includes a section to record family notification. Seven of the nine forms reviewed indicated family were informed or if family did not wish to be informed. Aria Park has an open disclosure policy. On interview ten residents (five rest home, five hospital), four family members (one rest home, three hospital) and seven caregivers all stated that family are informed following changes in the resident’s health status.

**Finding:**

Two of nine incident forms sampled do not document that family were informed. There is no recorded in the corresponding progress notes of family being informed. One of these incidents is for a significant sum of money being found around the room of a resident who is not competent to care for the money.

**Corrective Action:**

Ensure family are informed of all 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 1.1.13: 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:** PA Low

**Evidence:**

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with 10 of 10 residents (five rest home and five hospital), and four of four family members (one rest home and three hospital), inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  
There is a complaints register. A sample of the only two documented complaints for 2014 were reviewed. Verbal and written complaints are documented with no complaints being identified that have not been recorded on the complaint register. This is an improvement since the previous audit. All complaints are recorded in the complaints register. One of the two complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to the complainant. Both complaints are from one complainant and relate to the availability of kylies. Further kylies were purchased as a result of the complaint. The other complaint does not show documented evidence of a resolution letter being sent to the complainant. This is an area requiring improvement.   
Discussions with ten residents and four family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns.

##### 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:** PA Low

**Evidence:**

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with 10 of 10 residents (five rest home and five hospital) and four of four family members (one rest home and three hospital) inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  
A sample of the only two documented complaints for 2014 were reviewed. Verbal and written complaints are documented with no complaints being identified that have not been recorded on the complaint register. This is an improvement since the previous audit. One of the two complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to the complainant.

**Finding:**

One of the two complaints for 2014 does not show documented evidence of a resolution letter being sent to the complainant.

**Corrective Action:**

Ensure that all complaints are acknowledged, investigated and that the complainant is notified of the outcome 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 1.1.13.3 (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:**

Aria Villages is a Limited Liability Company, which includes three aged care facilities all located in Auckland. Two managing directors own the company. They are supported with an operations manager, facility manager (at each of their three locations), staff and contractors. The operations manager is responsible for oversight of the quality and risk management programmes.

The service can provide care for up to 130 residents with 86 beds certified as rest home level (including 46 serviced apartments) and 44 beds certified as hospital level. Ten beds in the rest home area can be used for either rest home or hospital level care. During the audit there were 37 rest home residents and 41 hospital residents living hospital and rest home wings. Additionally there is one hospital resident in the studio apartments and one rest home resident in the serviced apartment. The Ministry of Health has granted special dispensation for the hospital resident to be cared for in a studio apartment in a letter dated 23 September 2013.

There are no residents under the medical component of their certification and no residents on respite or under 65 years old.

The quality and risk planning for Aria Park Retirement Village reflects links to the organisation’s philosophy and vision, which are posted in frames in a visible location for residents and families to sight.

The facility manager has recently been appointed to this role (May 2014). She is a registered nurse with a current annual practising certificate. She has over 20 years of experience in the health and disability sector in senior leadership and management roles.

Interviews with seven caregivers and the clinical manager confirm their confidence in the newly appointed facility manager although they state they do not know her very well at this early stage of her appointment.

The manager is supported by an operations manager who is responsible for the organisation’s quality and risk management programmes and a clinical manager (RN) who has been employed by Aria Park for more than 15 years.

ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The manager is directly involved in operations at the facility and the clinical manager supports her in this role. There is a current quality improvement risk and management action plan that includes objectives/goals and a quality plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (seven caregivers, two registered nurses (RN's) and the clinical manager) inform an understanding of the quality activities undertaken at Aria Park  
Resident meetings occur monthly (minutes viewed). Ten of 10 residents interviewed are aware meetings are held. Annual satisfaction surveys are undertaken. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service. The 2013 resident and relative feedback survey resulted in a corrective action plan that continues to be in the process of implementation.   
D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans.  
D10.1: Following the death of a resident 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 such as physiotherapy reviews, instruction around prevention in care plans.  
  
Policies and procedures are in place with evidence of review. The manager manages quality systems. There is a quality team which includes staff from all areas. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly quality meetings. Meetings are reported to discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. However minutes have not been completed for the May, June and July 2014 quality meetings meaning it is difficult to follow issues through. This is an area requiring improvement. There is evidence of quality data (accidents/incidents, complaints and infection trends) being discussed at qualified staff monthly meetings. However meeting minutes of staff meetings show other staff are not aware of the outcomes of quality data analysis. The previously identified shortfall around informing staff of quality data analysis outcomes continues to require addressing.  
Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.  
Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet (link 1.2.4.3). Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Aria Park has three residents with restraints and five residents using enablers (link 2.1.1). However restraint is not discussed in quality meetings and this is a further area requiring improvement.  
There is a 2014 internal audit programme which includes all aspects of service delivery. There are series of audits which are repeated each month and then a schedule of other internal audits to be completed monthly. Where shortfalls are identified in the regular monthly audits there is no evidence of corrective action plans being developed. Some corrective action plans are developed when shortfalls are identified in other audits but there is no evidence of these having been implemented and signed off. The previously identified shortfall around corrective action planning continues to require addressing.   
Monitoring data that is collected by way of monthly: incident report, infection collation (link 3.5.7), and outcomes from internal audits is reported through to health and safety/infection control and staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. There is evidence of this data being analysed for trends and this is an improvement since the previous audit.   
Aria Park has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Seven caregivers interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

##### 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:** PA Moderate

**Evidence:**

The manager manages quality systems. There is a quality team which includes staff from all areas. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly quality meetings. Meetings are reported to discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. There is evidence of quality data (accidents/incidents, complaints and infection trends) being discussed at qualified staff monthly meetings.

**Finding:**

(I) Minutes have not been completed for the May, June and July 2014 quality meetings meaning it is difficult to follow issues through. (ii) Meeting minutes of staff meetings show other staff are not aware of the outcomes of quality data analysis. (iii) Restraint is not discussed at quality meetings for those meetings where minutes are available.

**Corrective Action:**

(i)Ensure quality meeting minutes are taken and made available and copies kept. (ii) Ensure all staff are informed of the outcomes of quality data analysis and trends. (iii) Ensure restraint is discussed in quality meetings or some other regular forum.

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

**Evidence:**

There is a 2014 internal audit programme which includes all aspects of service delivery. There are series of audits which are repeated each month and then a schedule of other internal audits to be completed monthly. Some corrective action plans are developed when shortfalls are identified in audits.

**Finding:**

Where shortfalls are identified in the regular monthly audits there is no evidence of corrective action plans being developed. Some corrective action plans are developed when shortfalls are identified in other audits but there is no evidence of these having been implemented and signed off.

**Corrective Action:**

Ensure that corrective action plans are developed when service shortfalls are identified and that corrective action plans are implemented and signed off when completed.

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

**Evidence:**

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the clinical manager, who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the registered nurse (RN) meetings and quality meetings (link 1.2.3.6). There were two skin tears noted in resident files where no incident form has been completed. This is an area requiring improvement.   
Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Public health were notified promptly of a norovirus outbreak in April 2014.   
A sample of nine incidents/accidents from April 2014 were viewed. The facilities policy and procedure on incident management were implemented.  
D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

##### 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:** PA Moderate

**Evidence:**

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the clinical manager, who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the RN meetings and quality meetings (link 1.2.3.6).

**Finding:**

There were two skin tears noted in resident files where no incident form has been completed.

**Corrective Action:**

Ensure incident forms are completed for all incidents.

**Timeframe (days):** 90 *(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 job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. All staff have employment contracts. The practising certificates of RN’s are current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist. Appointment documentation is seen on file including signed contracts, orientation, reference checks and training. All six staff files sampled (the clinical manager, one activities coordinator, the cook, two caregivers and one registered nurse) have completed performance appraisals where these are due.  
There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with four caregivers described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. However there has been no training around restraint use and the management of challenging behaviour. Attendance at trainings is low with less than 15 staff attending abuse and neglect, falls prevention and skin/pressure area risk management. These are areas requiring improvement.   
  
D17.7d: There are implemented competencies for RN's related to specialised procedure or treatment including (but not limited to); medication and syringe driver use.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept.

**Finding:**

There has been no training around restraint use and the management of challenging behaviour. Attendance at trainings is low with less than 15 staff attending abuse and neglect, falls prevention and skin/pressure area risk management.

**Corrective Action:**

Ensure training is provided around restraint and challenging behaviour management and that staff training attendance is such that all staff receive essential trainings.

**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:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical manager or the manager will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff.   
There is a registered nurse on duty at all times. The hospital resident in a serviced apartment has a caregiver in her in the apartment at all times 24 hours per day as funded by the family. The caregiver was present when the resident was sighted on three occasions during the 1.5 day audit and all staff interviewed report there is always a caregiver with the resident.  
A contractor physiotherapist attends the facility for six hours a week.

##### 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.)*

## 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 1.3.3: 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:**

Aria Park provides hospital and rest home level care. This audit reviewed seven resident files; four hospital – two from the ‘upstairs hospital’, one from the ‘down stairs’ hospital and one hospital level resident in the apartments. Three rest home files reviewed include two from the rest home and one from the apartments.

In all seven files reviewed the assessment of residents and the development of lifestyle support plans is undertaken by the service’s registered nurses who also have the responsibility for maintaining and reviewing support plans.   
All resident files including care plans documented that care plans are developed in consultation with other relevant people including residents and where appropriate family/whanau. This is documented well in the progress notes. On-going family communication is also documented.  
The seven files documented evidence of other allied health services input i.e. GP, physiotherapy, dietitian, occupational therapist and podiatry. Four family members (one rest home, three hospital) interviewed confirmed their involvement.   
Care workers complete progress notes at the end of each shift, the progress notes have ‘tick’ forms to indicate care that has been provided. Review of progress notes evidences that the ‘care provided’ tick sheets’ are not always completed (one for four hospital and one of three rest home). This is an area requiring improvement.

There is an appropriate hand-over briefing between shifts that staff were able to fully describe.  
D16.2, 3, 4: The seven files reviewed identified that in all files an assessment was completed within 24 hours and all files identify that the long term support plan was completed within three weeks.  
D16.5e: Seven resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly.  
  
Tracer Methodology:   
Rest home.  
XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Hospital:

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

##### 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:**

Progress notes are written by both caregivers and registered nurses and at least daily for hospital residents. This is an improvement on the previous audit.

The previous audit identified that physiotherapy interventions do not link into care plans. This audit found a short fall around physiotherapy interventions in one file. Specialist interventions for wounds and use of turning charts were also identified as shortfalls from the last audit have been rectified.

**Finding:**

Physiotherapy interventions and recommendations were not documented in one care plan. Progress notes care interventions ‘ tick templates’ are not always completed ( one hospital file and one rest home file)

**Corrective Action:**

Ensure physio interventions and recommendations are documented in the care plans. Ensure progress notes care interventions ‘tick templates’ are completed daily.

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

**Evidence:**

A range of assessment tools are available for completion on admission and review at least six monthly including (but not limited to); a) skin assessment, b) pressure area assessment, c) falls risk assessment, d) nutritional needs assessment, e) continence assessment, f) pain assessment, g) mini nutritional needs assessment and if required challenging behaviour assessments and management plans.

Seven resident files were reviewed and short falls were evidenced around the implementation of and signing of the service resident assessment process.

##### 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 Moderate

**Evidence:**

A range of assessment tools are available for completion on admission and review at least six monthly including (but not limited to); a) skin assessment, b) pressure area assessment, c) falls risk assessment, d) nutritional needs assessment, e) continence assessment, f) pain assessment, G) mini nutritional needs assessment and if required challenging behaviour assessments and management plans.

Seven resident files were reviewed and short falls were evidenced around the implementation of and signing of the service resident assessment process.

**Finding:**

In the four hospital level resident files reviewed; one has an incorrect nutritional needs form, and no pain assessment, one had an incomplete pain assessment, one had assessments that had not been reviewed six monthly. In the rest home one file has incomplete assessments, and one does not reflect the cultural status of the resident, and two files have incomplete assessments, and assessments not reviewed six monthly, weights are not documented as undertaken monthly in two resident files. Dietary needs forms have not been communicated to the kitchen for two resident files.

**Corrective Action:**

Ensure that all assessments are documented fully in a timely manner and dietary needs are communicated to the kitchen.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous audit identified an improvement was required in relation to the level of care described in lifestyle support plans. In resident files reviewed (three rest home, four hospital) there is a long-term comprehensive support plan template for all areas of care needs. Lifestyle support plans demonstrate service integration. Resident files include lifestyle support plans, short term care planning, notes by GP and allied health professionals, significant events, communication with families and notes as required by a registered nurse. A review of long term care plans evidences that interventions for resident care remain a finding from the previous audit.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Seven care plans reviewed for this audit, three at rest home and four hospital, observation of care provided and interviews with seven caregivers’ evidences that caregivers are very knowledgeable about the care needs of the residents and that residents are well cared for. In resident files reviewed there is a long-term comprehensive support plan template for all areas of care needs. Lifestyle support plans demonstrate service integration. Resident files include lifestyle support plans, short term care planning, notes by GP and allied health professionals, significant events, communication with families and notes as required by a registered nurse

**Finding:**

Of the three rest home resident files reviewed; one did not have any cultural care included for a resident of a different culture. In the hospital, of the four resident files reviewed; one with no interventions for pain where pain is an identified problem one with diet and feeding interventions not documented and two with no weight management where weight management is an identified problem, and one with pressure area care not well documented.

**Corrective Action:**

Ensure that all identified resident problems have interventions documented in the residents’ LTCP

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The care being provided is consistent with the needs of residents. This is evidenced by discussions with (seven) caregivers, ten residents (five rest home, five hospital) and four family members (one rest home, three hospital) and two registered nurses.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.  
Continence products are available and resident files include an assessment for continence products identified for day use, night use, and other management.  
Specialist continence advice is available as needed and this could be described.  
Continence management and wound management in-services are provided as part of the annual in-service education plans.  
Wound assessment and wound management plans are in place for residents.

The registered nurses (two) interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Care plans are goal oriented and reviewed six monthly for rest home and hospital residents by a registered nurse.   
During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and family members were able to confirm this observation.   
GP interviewed confirmed that staff are prompt at communicating changes in resident health status and complete interventions as requested.

There are ten wounds in the rest home, including one pressure area, wound care plans are in place for all identified wounds, however one has three skin tears on one wound form and the pressure sore does not state the grade.

Hospital upstairs has six identified wounds including one pressure sore. Wound care plans are documented well with the exception of the pressure sore which does not state the grade. Hospital downstairs has four identified wounds these four wound plans all have documentation problems. Improvement is required around wound care documentation.

Wounds identified have no short term care plan in place. Short term care plans for other conditions such as UTI had not been reviewed and there was no short term care plan for a resident with diarrhoea. This is an area requiring improvement.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There is a process in place to manage wounds at this service. Each area files wound assessments, wound care plans and evaluations in a separate file. The wound care policy and procedure describes the process for wound care. Wound care templates in place are appropriate.

**Finding:**

There are ten wounds in the rest home (including one pressure area). Wound care plans are in place for all identified wounds; however one has three skin tears on one wound form and the pressure sore does not state the grade.

Hospital upstairs has six identified wounds including one pressure sore. Wound care plans are documented well with the exception of the pressure which does not state the grade. Hospital downstairs has four identified wounds these four wound plans all have documentation problems including pain assessments not documented as per plan for two wounds, one has no initial assessment and one wound identified through the progress notes has no wound care plan (this wound is a pressure sore).

Wounds identified has no short term care plan in place. Short term care plans for other conditions such as UTI had not been reviewed and there was no short term care plan for a resident with diarrhoea.

**Corrective Action:**

Ensure STCPs are in place for short term of acute events. Ensure wound care plans are in place for all wounds, and that wound care plans and assessments describe the wound and the care needed.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is an activities person who works Monday to Friday and a newly qualified DT. Between them they provide 30 hours a week activities in the rest home and 30 hours activities in the hospital.

There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on notice boards. Residents are encouraged to participate in activities in the community.   
There is a range of activities offered, that reflect the resident needs including but not limited to: newspaper reading, communion, church services, exercises, visiting entertainment, seasonal celebrations, hand massages, music, quizzes, baking, stories, craft, games, happy hour, van outings, shopping, movies, and crosswords. The activity programme is developed with the residents (and relatives).

Five rest home and five hospital residents all said the activities provided were good.

Individual activity plans in resident files, community links and attendance records are identified as an area for improvement.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on notice boards. Four hospital and three rest home resident files reviewed. In the rest home one of three files has an individual activities plan documented, all four hospital level resident files has an individual activities plan for each resident.

**Finding:**

Two of three rest home level residents did not have a documented individualised activity plan for each resident. Two of four hospital level activity plans do not document six monthly reviews. A review of the activity plans for the service does not document community links and attendance sheets for activities do no document level of involvement.

**Corrective Action:**

Ensure all residents have an up to date individualised activity plan. Ensure that community links are maintained and attendance sheets record level of involvement with activities.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D16.4a Lifestyle care plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur (link 1.3.6.1). There is at least a one- three monthly review by the medical practitioner. Multi-disciplinary reviews also occur and include family/EPOA.

Changes to the long term lifestyle care plan are made as required and at the six monthly review if required.

ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medicines policies and procedures are documented. The medicine management system complies with legislation and guidelines. The robotic medication administration system has been implemented. Residents' medicines profiles are reviewed three monthly by the GPs. Medicines are reconciled by a registered nurse on arrival at the service. The pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. Controlled drugs are stored in a locked safe and recorded in the controlled drug register which is up to date.

Staff responsible for medicine management are competent to perform this function. Registered and enrolled nurses who administer medication receive training on an individual basis at the time their annual competency is assessed. These are up to date. .

The service has policies around self-administration of medication.

All documents and signing sheets are completed in ink and legible. Signature registers for staff and GPs are available to verify signatures in place.

D16.5.e.i.2; All 14 medicines charts sighted identified that the GP had seen the reviewed the resident monthly and the medication chart was signed. All administration sheets were appropriately signed. The controlled drug register is up to date.

This audit identified shortfalls around transcribing, which remains a finding from the previous audit; new findings are around staff signing on administration, storage of medication and Blood Sugar Levels prior to insulin administration.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Medicines policies and procedures are documented. The medicine management system complies with legislation and guidelines. The robotic medication administration system has been implemented. Residents' medicines profiles are reviewed three monthly by the GPs. Medicines are reconciled by a registered nurse on arrival at the service. The pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. Controlled drugs are stored in a locked safe and recorded in the controlled drug register which is up to date.

**Finding:**

In the rest home; there were four medication charts instances of regular medications not signed for, the use of ‘white out’ on a chart and one instance of transcribing. In the hospital there was one instance of medication not signed on administration. A resident who had BSLs prior to insulin has the BSL taken two hours prior to the insulin and results stored in a separate file. The medication fridge contained out of date XXXXX and XXXXX not dated on opening. During resident interviews it was also observed that medication had been left on a resident’s table for them. This medication had been signed as given.

**Corrective Action:**

Ensure that medications are signed when given, Transcribing must cease. Ensure medications are checked to ensure they are all in date and dated on opening as needed. BSLs prior to insulin should be taken close to the time of administration and the results easily available to the administrator.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

Policies on food service are developed and implemented. The cooking is completed by two cooks and five kitchen hands to cover the seven day period. All have completed food safety training. Five weekly menus are reviewed by a dietitian and this last occurred on May 12. Daily temperature checks of chiller, freezers, and fridge are maintained. Food is transported to each area in a Bain Marie and served from kitchenettes

The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. (Link also to 1.3.4.2) This is reviewed six monthly as part of the care plan review. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff.

The clinical manager interviewed reports that dietitian input is available for individual residents if needed. The registered nurses report that any weight loss is discussed with the GP and this was confirmed by the GP during interview. The service caters currently for (but not limited to) diabetics, those requiring high protein diets, and cultural requests (one resident has a daily boil-up). Individual needs are catered for. Extra snacks are provided when needed.

##### 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 1.4.2: 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:**

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 21 December 2014. Electrical equipment is checked. This was last carried out in February 2013. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.  
Not all medical equipment has been calibrated. This is an area requiring improvement. Advised since the draft report, oxygen and scales calibrated and serviced May 2014.  
ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

##### 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:**

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires on 21 December 2014. Electrical equipment is checked. This was last carried out in February 2013.

**Finding:**

Not all medical equipment has been calibrated.

**Corrective Action:**

Ensure all medical equipment is calibrated according to the manufacturer’s instructions.

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

# 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:**

There is a restraint policy and manual with associated procedures and templates. The policy states that the use of restraints is kept to a minimum and that care staff who may be involved in restraint and enabler use have sufficient knowledge and skill to be able to ensure resident safety.  
The restraint policy and procedure includes definitions such as use of restraint, types of restraint permitted, use of enablers, enablers permitted, client rights, assessment, discussion, restraint alternatives, monitoring and removal. There is a restraint/enabler assessment form, consent form and monitoring form. Aria Park has three residents with restraints in the form of bedrails. The restraint policy requires that the service considers alternatives to restraint prior to any intervention. The policy also includes procedures for the use of restraint, cultural considerations, guidelines for restraint use and monitoring. On-going consultation with the resident and family/whanau is also identified.  
The service identifies enablers as items which are voluntarily used for safety. There are five residents with bed rails that are classified as enablers. However a review of three files for residents with enablers demonstrates that they are referred to in the care plan as restraints and that the resident is unable to consent to the bedrail, meaning they are not voluntary and therefore are restraints. This is an area requiring improvement.  
The restraints policy defines enablers as being voluntary use of equipment e.g. for safety for the resident. Restraint minimisation training and challenging behaviour training has not occurred (link 1.2.7.5). All ten caregivers interviewed could describe processes around enabler, restraint and challenging behaviour practice.  
The service has clear documentation to guide staff in the use of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is.

##### 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:**

The service identifies enablers as items which are voluntarily used for safety. There are five residents with bed rails that are classified as enablers.

**Finding:**

A review of three files for residents with enablers demonstrates that they are referred to in the care plan as restraints and that the resident is unable to consent to the bedrail, meaning they are not voluntary and therefore are restraints.

**Corrective Action:**

Ensure the use of enablers is voluntary.

**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 3.5: 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:** PA Low

**Evidence:**

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.   
The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly quality meetings (minutes viewed) (link 1.2.3.6). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.

A review of resident files showed one upper respiratory tract infection and one wound infection that were not included in the infection monitoring data. This is an area requiring improvement.

##### 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:** PA Low

**Evidence:**

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.   
The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly quality meetings (minutes viewed) (link 1.2.3.6). The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.

**Finding:**

A review of resident files showed one upper respiratory tract infection and one wound infection that were not included in the infection monitoring data.

**Corrective Action:**

Ensure all infections are included in the infection monitoring data.

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