

Radius Residential Care Limited - Radius Rimu Park

Current Status: 5 August 2014

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

General overview

Rimu Park is part of the Radius Residential Care Group. The service provides cares for residents requiring hospital, rest home and psychogeriatric level care. On the day of the audit there were six residents receiving rest home level care, 15 receiving hospital level care and 19 receiving psychogeriatric level care.

The facility manager is a registered nurse with many years of aged care management experience. The manager has been at the service for nine weeks and is supported by an experienced clinical manager and Radius regional manager. The organisation has adopted a quality approach towards service delivery and incorporating quality into all aspects of care.

Two areas for improvement have been identified around quality data analysis and care plan interventions.

Audit Summary as at 5 August 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

Indicator	Description	Definition
	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 5 August 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 5 August 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 low risk.
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Continuum of Service Delivery as at 5 August 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.
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Safe and Appropriate Environment as at 5 August 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 5 August 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 5 August 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 5 August 2014

Consumer Rights

Rimu Park practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and throughout the care planning process. There are implemented policies at Rimu Park to protect residents from discrimination or harassment. Clinical policies are reviewed by the clinical management committee at organisational level and there is a process in place to inform staff of policy change. There is an open disclosure and interpreters policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy and an up to date register. Staff interviews confirmed an understanding of the complaints process.

Organisational Management

Rimu Park is part of the Radius group and as such, there are organisational wide processes to monitor performance. The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is a quality system that is being implemented in line with the quality plan (2014). Combined staff/quality improvement meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. There is an improvement required around quality data analysis. There is an adverse event reporting system implemented at Rimu Park and monthly data collection monitors predetermined indicators. There is a human resource manual to guide practice. There is an annual education programme and records of attendance are maintained. Staff files reviewed included current appraisals and demonstrated that human resource practices were followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts. Resident information is kept confidential and old records are archived.

Continuum of Service Delivery

The residents' records reviewed provide evidence that all residents have been assessed appropriately prior to admission to this facility by the needs assessment service co-ordinators. The provider has an implemented system to assess, plan and evaluate the care needs of the

residents. The residents' needs, outcomes and/or goals have been identified in the assessments and care plans are reviewed six monthly or more often as required. There is an improvement required around care planning and interventions. A team approach to care delivery and continuity of service delivery is encouraged.

Medication management is safely implemented. A visual inspection of the medication systems and the lunchtime medication round evidences compliance with respective legislative requirements, regulations and guidelines. There is evidence of the three monthly medication reviews being completed by the general practitioners. These reviews are completed more frequently if required. The contracted pharmacist audits the medication records and controlled medications. The medication system is in the form of blister packs.

Food services are managed effectively. Meals are prepared on site. Nutritional guidelines and advice is available. The menu plans have been reviewed by a dietitian and are suitable for the residents. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Meals are provided at appropriate times of the day.

An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme. A separate activities programme is provided in the psychogeriatric unit.

Safe and Appropriate Environment

Resident rooms provide single accommodation and there are adequate shower and toilet facilities. Residents' rooms in all wings/units are large enough to allow for the safe use of mobility and lifting aids. There is a main lounge and dining area in each area and other lounge areas. Outdoor areas are available and seating and shading is provided. There is a large internal courtyard. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. All laundry is completed off site. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. The cleaning and laundry system includes monitoring systems to evaluate the effectiveness of the service. Staff have completed appropriate training in chemical safety. There are appropriate systems in place to ensure the physical environment is safe, and facilities are fit for their purpose.

Restraint Minimisation and Safe Practice

The restraint minimisation and safe practice policy 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 an enabler register. Restraint assessments are based on information in the care plan, discussions with residents/relatives and on staff observations of residents. Staff are trained in restraint minimisation and restraint competencies are completed

regularly. Restraint is reviewed for each individual at least monthly and as part of the multidisciplinary review. Multidisciplinary reviews include family/whanau.

Infection Prevention and Control

Radius Rimu Park has an infection control programme that complies with current best practice. There is a dedicated infection control coordinator who has a role description. The infection control coordinator collates monitoring data and reports through to the quality meetings and RN meetings. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

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:	Radius Residential Care Limited
Certificate name:	Radius Residential Care Limited - Radius Rimu Park
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Radius Rimu Park
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 August 2014 End date: 6 August 2014
Proposed changes to current services (if any):	The service is planning to alter the building to incorporate three current rest home/hospital rooms into psychogeriatric rooms within the psychogeriatric unit.
Total beds occupied across all premises included in the audit on the first day of the audit:	40

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXX	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	XXXXX			Hours	1

Sample Totals

Total audit hours on site	24	Total audit hours off site	13	Total audit hours	37
Number of residents interviewed		Number of staff interviewed	14	Number of managers interviewed	3
Number of residents' records reviewed	7	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	52	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 8 September 2014

Executive Summary of Audit

General Overview

Rimu Park is part of the Radius Residential Care Group. The service provides cares for residents requiring hospital, rest home and psychogeriatric level care. On the day of the audit there were six residents receiving rest home level care, 15 receiving hospital level care and 19 receiving psychogeriatric level care. The facility manager is a registered nurse with many years of aged care management experience. She has been at the service for nine weeks and is supported by an experienced clinical manager and Radius regional manager. The organisation has adopted a quality approach towards service delivery and incorporating quality into all aspects of care. Two areas for improvement have been identified around quality data analysis and care plan interventions.

Outcome 1.1: Consumer Rights

Rimu Park practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights "the Code" and copies of the code are displayed through the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process. There are implemented policies at Rimu Park to protect residents from discrimination or harassment. Clinical policies are reviewed by the clinical management committee at organisational level and there is a process in place to inform staff of policy change. There is an open disclosure and interpreters policy that staff understand. Family/friends are able to visit at any time and interviews verified on-going involvement with community activity is supported. There is a complaints policy supporting practice and an up to date register. Staff interviews confirmed an understanding of the complaints process.

Outcome 1.2: Organisational Management

Rimu Park is part of the Radius group and as such, there are organisational wide processes to monitor performance. The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is a quality system that is being implemented in line with the quality plan (2014). Combined staff/quality improvement meetings are used to monitor quality activities such as audit, complaints, health and safety, infection control and restraint. There is an improvement required around quality data analysis. There is an adverse event reporting system implemented at Rimu Park and monthly data collection monitors predetermined indicators. There is a human resource manual to guide practice. There is an annual education programme and records of attendance are maintained. Staff files reviewed included current appraisals and demonstrated that human resource practices were followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts. Resident information is kept confidential and old records are archived.

Outcome 1.3: Continuum of Service Delivery

The residents' records reviewed provide evidence that all residents have been assessed appropriately prior to admission to this facility by the needs assessment service co-ordinators. The provider has implemented a system to assess, plan and evaluate the care needs of the residents. The residents' needs, outcomes and/or goals have been identified in the assessments and care plans are reviewed six monthly or more often as required. There is an improvement required around care planning and interventions. A team approach to care delivery and continuity of service delivery is encouraged.

Medication management is safely implemented. A visual inspection of the medication systems and the lunchtime medication round evidences compliance with respective legislative requirements, regulations and guidelines. There is evidence of the three monthly medication reviews being completed by the general practitioners. These reviews are completed more frequently if required. The contracted pharmacist audits the medication records and controlled medications. The medication system is in the form of blister packs.

Food services are managed effectively. Meals are prepared on site. Nutritional guidelines and advice is available which is appropriate for this service setting. The menu plans have been reviewed by a dietitian and are suitable for the elderly and/or disabled residents. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Meals are provided at appropriate times of the day.

An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme. A separate activities programme is provided in the psychogeriatric unit to the rest home/hospital.

Outcome 1.4: Safe and Appropriate Environment

Resident rooms provide single accommodation and there are adequate shower and toilet facilities. Residents' rooms in all wings/units are large enough to allow for the safe use of mobility and lifting aids. There are a main lounge and dining area in each area and other lounge areas. Outdoor areas are available and seating and shading is provided in external areas. There is a large internal courtyard. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry and emergency management, and these are known by staff. All laundry is completed off site. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of adequate sluice facilities, safe and hygienic storage of chemicals, cleaning equipment, and soiled linen. Protective equipment and clothing is provided and is used by staff. The cleaning and laundry system includes appropriate monitoring systems to evaluate the effectiveness of the service. Staff have completed appropriate training in chemical safety. There are appropriate systems in place to ensure the physical environment is safe, and facilities are fit for their purpose.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Meeting minutes did not always reflect review and analysis of benchmarking data and evidence of discussion, and opportunities for improvement	Ensure documentation reflects review, analysis of benchmarking data and opportunities for improvement identified, implemented and evaluated.	180
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	(a)The following shortfalls are identified in residents files: (i) Resident 1) (psychogeriatric resident) Following an incident on 1 June 2014 the resident was assessed as needing two staff for lifting in the shower. This is documented on the health care assistant handover sheet but the care plan has not been updated and still states: one person assist'. (ii) Resident 2) (rest home resident) The dietitian stated the resident should be weighed weekly. This has not occurred. (iii) Resident 3) (hospital resident) The care plan does not address XXXXXX. The resident has had a sustained weigh loss of one	(i)Ensure all identified needs are addressed in the care plan. (ii) Ensure that care plans are updated when needs change. (iii) Ensure that allied health professionals such as dietitian and GP instructions are followed. (iv) Ensure that abnormal laboratory results are communicated to the GP in appropriate timeframes. (ii) Ensure weight loss is appropriately addressed with dietitian referrals and care plan updates. (v) Ensure that two hourly turns occur regularly and that these are documented. (vi) Ensure that wounds are reviewed within stated time	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>kilogram per month for the past eight months. There has been no dietitian referral and this has not been addressed in the care plan. The GP requested a follow up blood test in two weeks at the end of May 2014. This did not occur. When the GP identified this at the end of July 2014 the repeat blood test was completed. The result was a sub therapeutic level and the RN documented she informed the GP at 1835 hours on 28 July 2014. On 5 August 2014 the GP documented that she had not been informed of the result until that day. The GP confirmed during interview that she had not been informed of the blood test result. (iv) Resident 4) (hospital resident) The assessment indicates that staff should ensure the resident is fully alert and positioned upright before feeding her. Also she is to have sub cut fluids if fluid intake is below 1000 mls. These care interventions are not addressed in the care plan. The resident's two hourly turning chart also indicates that regular two hourly turns have not always occurred. (b) Two of five wounds (including one of two pressure areas) have not always been reviewed within the stated timeframe.</p>	frames.	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

There is an implemented code of rights policy and procedure. Discussions with six health care assistants (two from the psychogeriatric units and four from the hospital/RH) and four registered nurses (two from the psychogeriatric units, two from the hospital/RH) identified their familiarity with the code. Interviews with seven residents (three rest home, four hospital) and seven relatives (three from the hospital/RH and four from the psychogeriatric unit) confirmed service is provided in line with the code of rights. Code of rights/advocacy training was last provided in May 2014 (total of 16 attended).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The service provides information to residents that includes the code of rights, complaints and advocacy information. There is access to interpreter services if required. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with seven residents and seven relatives (one hospital, two rest home and four from the psychogeriatric unit) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints.

Monthly resident/relative meetings (minutes sighted) are held providing the opportunity to raise concerns in a group setting. There is a regular newsletter available to residents and families.

Advocacy pamphlets are included in the information pack. Advocacy service pamphlets available in facility that include contact details. The service has an advocacy policy that includes a definition of advocacy, objectives and process/procedure/guidelines.

D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and H&D Commission information.

ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has policy aligned with the requirements of the Privacy Act and Health Information Privacy Code - including: Confidentiality, privacy & dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.

Discussions with seven residents (three rest home and four hospital) and seven relatives (one hospital, four psychogeriatric (PG) unit, two rest home) confirmed personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.

D3.1b, d, f, i the service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

The spiritual and religious beliefs policy guides practice from an organizational perspective. Interdenominational services are held weekly. Contact details of any spiritual/religious advisors are available to staff. Religious dietary requirements identified through assessment and care planning and met as required. All seven residents confirm the service is respectful.

A client satisfaction survey is carried out annually to gain feedback. In the survey completed in August 2013, respondents indicated (100%) they were satisfied that cultural and spiritual/religious needs being met. In regards to privacy and code of rights, 90% were satisfied.

D4.1a: Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

The information pack provided to residents and their families includes the home's philosophy of care. Discussions with seven residents confirmed that residents are able to choose to engage in activities and access community resources. Residents and family members confirmed that they have adequate rights to choose within the constraints of the service, for example, meal times.

Seven care plans reviewed (two rest home, two hospital, three psychogeriatric (PG) identified specific individual likes and dislikes.

The abuse & neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Training is an annual requirement. All facilities are required to have a copy of the "Elder Abuse & Neglect - a Handbook for those working with Elder Abuse" from Aged Concern.

Abuse and neglect training occurred in May 2014 (15 attended).

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

ARHSS D4.1b Three psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a specific Maori Health care plan and a culturally safe care policy. Discussions with six healthcare assistants and four registered nurses confirm an understanding of the different cultural needs of residents and their whānau. There is a section in the assessment tool and care plan that includes spirituality, religion and culture, psycho-social needs and family and significant others. In addition there is a Maori care plan available if the individual resident wishes. There are six Maori residents at Rimu Park. There is information and websites provided within the Maori Health Plan to provide quick reference and links with local Maori Healthcare Providers regionally within New Zealand.

D20.1 i: The service has links to local Iwi.

The Maori Health plan states that staff training sessions will be provided two yearly for all staff. Cultural safety training was provided in March 2014. The service has documentation relating to culturally appropriate responses in particular settings.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Policies include guidelines about the importance of whānau.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Care planning includes consideration of spiritual, psychological and social needs. Seven residents (three rest home, four hospital) indicated that they are involved in the identification of spiritual religious and or cultural beliefs. There are regular church services at Rimu Park. Seven relatives (two from the rest home, one from the hospital and four from the psychogeriatric unit) interviewed stated that they felt they were valued, consulted and kept informed. Family involvement is encouraged e.g. invitation to facility functions.

D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by six health care assistants (two from the psychogeriatric units and four from the hospital/rest home) and four registered nurses (two from the psychogeriatric units, two from the hospital/ rest home).

D4.1c Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

ARHSS D4.1d: Three care plans reviewed from the psychogeriatric unit included the resident's social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There is an implemented discrimination and harassment policy that includes all aspects of this criterion. There is a staff policy in relation to gifts and gratuities and the management of external harassment. The following policies also support keeping residents safe from exploitation: code of resident's rights, abuse and neglect, and complaints. Annual training is provided to staff across a number of topics such as: code of rights May 2014 (total of 16 attended).

A staff employment handbook and orientation package includes a code of behaviour. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with six health care assistants and four registered nurses, the clinical manager and the activity therapist informed an understanding of professional boundaries.

ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two health care assistants from the psychogeriatric unit could describe how they build a supportive relationship with each resident. Interviews with four families from the psychogeriatric unit confirmed the staff assist to relieve anxiety.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. Policies are reviewed and approved by the clinical management committee at an organisational level. The good practice policy supports staff in ensuring good practice is intrinsic to care delivery. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The human resource manual includes pre-employment, the requirement to attend orientation and on-going in-service training. The education and training officer (RN) and the clinical manager report a focus on staff training and this is confirmed by staff interviewed.

Rimu Park facility manager oversees the internal audit and in-service education programmes with support from senior staff. Staff are informed when external training is available and financial support is considered. Staff regularly attend Aged Concern training courses in Whangarei (sited). There is support available for those wishing to pursue post-graduate qualifications (appropriate to the area of work). There is access to computer and internet resources and search engines. There is organisational membership to Bug Control for infection control updates / training and expert advice.

There are monthly quality/staff meetings and intermittent registered staff meetings and monthly resident/relative meetings.

Seven residents and seven relatives interviewed spoke positively about the care and support provided. Six health care assistants and four registered nurses, the management team and activity therapist have a sound understanding of principles of aged care and state that they have been supported by the service for on-going education.

A2.2: Services are provided at Rimu Park that adhere to the Health & Disability Services Standards (2008). There is an implemented quality improvement programme that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c. There are implemented competencies for healthcare assistants, and registered nurses including restraint, manual handling, hand hygiene and fire safety, medication and syringe driver (for registered nurses). There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy. The communication with resident's policy includes procedures to ensure that staff communicate well with residents and family members. There are monthly resident/relative meetings facilitated by the activities staff allowing residents/relatives to raise issues. Seven residents (four hospital, three rest home) stated that communication was good and they were given time and explanation about services and procedures provided on entry.

Eighteen incident reports were reviewed (11 PG, seven hospital/rest home). All recorded family notification. Seven relatives (one hospital, two rest home and four from the psychogeriatric unit) informed they are notified of any changes in their family member's health status. The clinical manager, who investigates incidents, informed there are processes in place to support family notification of events.

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: All seven relatives stated that they are informed when their family members health status changes.

The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.

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

ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to the PG unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.

The 2013 resident/relative survey identified that 100% stated they felt they were fully informed. 84% stated communication was good.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and training support staff in providing care and support to enable residents to make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with six healthcare assistants identify that consents are sought in the delivery of personal cares. Written consent includes the signed admission agreements seven resident files (two from the rest home, two from the hospital and three from the psychogeriatric unit), included consent for transporting, photographs and provision of care. All seven resident files reviewed included signed consent forms signed by the family/whanau/EPOA. Advanced directives / resuscitation policy is implemented in the resident files reviewed. All advance directives are completed by the resident where able, the GP and discussion with family members is documented.

D13.1: There were seven admission agreements sighted and all had been signed on the day of admission.

D3.1.d: Discussion with seven relatives (one hospital, two rest home and four from the psychogeriatric unit) identified that the service actively involves them in decisions that affect their relative's lives.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA

Evidence:

There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and advocacy pamphlets are available at reception.

D4.1e; The resident file includes information on residents family/whanau and chosen social networks

Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.

D4.1d; Discussion seven relatives (one hospital, two rest home and four psychogeriatric unit) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The client information pack informs visiting can occur at any reasonable time. Interviews with seven residents and seven relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans and there is a family communications/contact sheet in resident files where staff document when family have been contacted.

The service has strong community support and engagement.

D3.1.e Discussion with residents and relatives verified they are supported and encouraged to remain involved in the community and external groups.

D3.1h: Relatives interviewed indicated that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The complaints policy and procedure states that clients/family/whanau shall have access to a complaints system whereby they can express concern without prejudice and those concerns are addressed. Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and complaint forms or via suggestion box.

A client's complaint procedure flow chart is included in the policy and is included in the information pack for residents on entry. Policy states that complaints process is to be visible and available in public areas.

Interviews with seven residents and seven relatives were familiar with the complaints procedure and state all concerns /complaints are addressed. The 2013 satisfaction survey 100% identified they were satisfied their concerns are addressed.

The complaints log/register includes date of incident, complainant, summary of complaint, signature off as complete. There have been five written complaints and three verbal complaints in 2014 year to date (YTD). All have documentation of full investigation and resolution including communication with complainants is documented for all complaints.

There have been two HDC complaints (2013), both are now closed out and one DHB complaint.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Rimu Park is part of the Radius Residential Care Group. Rimu Park cares for residents requiring hospital (geriatric and medical and psychogeriatric) and rest home level care. The facility can cater for up to 53 residents (19 bed PG unit) and (34 bed dual-purpose hospital/rest home). On the days of audit there were 19 residents in the PG unit and six rest home, and 15 hospital residents.

The facility manager reports monthly to the Regional Manager on a range of operational matters in relation to Rimu Park including strategic and operational issues, incidents and accidents, complaints, health and safety. Radius mission statement states that: "We deliver a quality lifestyle with an innovative approach to care that enables us to maintain the wellbeing, dignity and independence of our residents"

Radius has an organisational philosophy, which includes vision, mission statement & objectives including quality/risk management framework & process policy. Annual business quality/risk management plans are in place (sighted for 2014). A quality/risk management plan for 2014 has been developed for Radius Residential Care and Rimu Park has developed site specific objectives including:

1. Clinical and Operational key performance indicators
2. Clinical effectiveness
3. Consumer participation
4. Workforce effectiveness
5. Risk management
6. Taking ownership of the business and services provided
7. Effective financial leadership and management
8. Cost containment and reduction.

The service has a documented structure that supports continuity of management and care delivery. The facility manager (RN) has been in the role for the last nine weeks. She also has over nine years' experience in mental health and aged care and has been in aged care management for the last six years. She is supported by an experienced clinical manager who has been at the service for 1.5 years and the Radius regional manager.

The organisation provides annual conferences for their managers and annual regional conferences. ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

During the temporary absence of the manger, Rimu Park is managed by the clinical manager with support from the regional manager. The clinical manager has been at the facility for 1.5 years.

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

ARHSS D4.1a: The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is an organisational quality/risk management plan - 2014 that includes clinical/care related risks, human resources; health and safety; environmental/service; financial; as well as site specific risks/goals identified for Rimu Park.

There are organisational policies to guide each facility to implement the quality management programme including (but not limited to); continuous quality improvement programme policy, continuous quality improvement methodology policy, quality indicator data collection policy and internal audit timetable.

Interviews with registered nurses and healthcare assistant confirmed that quality data is discussed at staff meetings. Significant trends are also discussed in RN meetings. There is a monthly staff/quality meeting. Minutes of these meetings are made available to all staff. There is an improvement required to ensure documentation reflects review, analysis of benchmarking data and opportunities for improvement identified, implemented and evaluated.

The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management. Assessment tools completed linked with resident care plans and were reviewed six monthly. There is an annual staff training programme that is implemented and based around policies and procedures. Internal audits are completed for care delivery compliance, care plans compliance, clinical records, medications, hand washing, privacy.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D5.4 The service has the appropriate policies and procedures to support service delivery; There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly. New/updated policies are sent from head office. New policies/procedures are put in the staff room with a signing sheet for staff to sign once they have read and understood the documentation (verified at interview with 10 healthcare assistants and six registered nurses). Staff have access to manuals (nurse's stations). Policies are up to date and are located electronically on 'P' drive.

Monthly reports by the facility manager to the regional manager are provided on service indicators. The quality/staff meetings are minuted and with a set agenda including (but not limited to): health & safety, incident and accidents, complaints/compliments. Information is taken to staff through the various meetings, and staff notice boards.

There are monthly accident/incident reports completed by the clinical manager that break down the data collected across the service.

The service has linked the complaints process with its quality management system. Monthly manager reports to the regional manager include complaints. Staff meeting minutes identify discussion of complaints.

There is an infection control data collection form which records all infections for each month. Infection control rates, outbreaks and results of internal audits are reported to the staff meeting and through clinical indicator reports for benchmarking. A range of infection control internal audits are planned and undertaken during the year. Results are forwarded to the staff, and registered nurse meetings.

Health and safety is an agenda item of the quality/staff and RN meetings. Any new hazards are discussed.

The restraint committee meet monthly; feedback is provided to staff/quality and RN meetings. Restraint use is also fed back to the organisation through the clinical indicator reports. Restraint internal audits are completed yearly and results are also forwarded through monthly manager meetings

Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Rimu Park by the Facility Manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, IC, medications, code of rights, informed consent, vehicle compliance and restraint. Minutes of RN meetings verified audit results are discussed.

Radius policy informs a corrective action plan is required where compliance is under a predetermined threshold. Corrective action plans were developed for incident reports (sighted) and all audits where there has been less than 95% conformity.

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 aggregating data monthly that includes considering time of occurrence

There is emergency and disaster planning in place around earthquakes, fire, emergencies and other disasters. This includes training and education for staff, monthly building compliance checks, six monthly evacuation trials, and ensuring adequate staffing in the event of an emergency. There is an organisational risk register that includes identified risk and risk rating, identified action to prevent or minimize risk and persons responsible and covers areas such as clinical risk, human resources related risks, health and safety risks, environment/service related risks and financial risk. Each facility personalises to their site. Radius has terms of reference for the H&S committee defining membership to include healthcare assistants and a household representative.

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 Low

Evidence:

Radius benchmarks its own facilities against predetermined indicators that are reported monthly from facilities. Further evidence may be requested by the regional manager when indicators are above the benchmark. The service collects internal monitoring data (internal audits) with the audit schedule being implemented at Rimu Park by the Facility Manager. The audit programme includes (but not limited to); care plans, care delivery compliance, health and safety, Infection Control, medications, code of rights, informed consent, vehicle compliance and restraint. Minutes of RN meetings verified audit results are discussed.

Finding:

Meeting minutes did not always reflect review and analysis of benchmarking data and evidence of discussion, and opportunities for improvement

Corrective Action:

Ensure documentation reflects review, analysis of benchmarking data and opportunities for improvement identified, implemented and evaluated.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the

status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

As part of risk management and health and safety framework, there is an accident/incident reporting and open disclosure policy/procedure. There was evidence of indicator month by month data collection including (but not limited to): falls (no injury, soft tissue, and fractures), skin tears, medication and pressure areas.

When an incident occurs the healthcare assistant (or staff discovering the incident) completes the form and the RN will undertake an initial assessment. The RN will notify family and GP as required. The clinical manager collects incident reports daily and review both the incident and actions taken. Eighteen incident forms were reviewed (11 PG, seven hospital/rest home), each detailed investigations and corrective action plans following incidents.

The six healthcare assistants and four registered nurses interviewed could describe the process for management and reporting of incidents and accidents.

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

D19.3c Discussions with the service (regional manager, clinical manager and facility manager) confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications.

Accident/incident analysis includes falls, skin tears, pressure areas, resident behaviour and medication incidents. The service has an incident and accident analysis form that includes name, place, date and time, type, injury/site, cause, resident/staff/visitor, doctor notified, hazards identified and action taken. Monthly aggregation of data is undertaken advised and outcomes are discussed at all meetings – staff/quality, and RN meetings (link 1.2.3.6).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

New registered staff are required to provide a practising certificate as part of the recruitment process. Practising certificates are sighted for: GP's, physiotherapist, pharmacy, podiatrist and dietitian.

Recruitment, selection and appointment of staff policy is in place. Eight staff files were reviewed, four have a current performance appraisal (the other four have been with the service less than one year).

The organisation has a staff orientation policy. Rimu Park has an orientation programme that is specific to worker type and includes manual handling, health and safety in service and competency testing. The new staff member is then buddied for three shifts with an experienced healthcare assistant (HCA). The facility manager identifies suitably skilled health care assistant (HCA) to be the 'buddy'. Interview of 10 health care assistants (five from the psychogeriatric units and five from the hospital) and five registered nurses (two from the psychogeriatric units, two from the hospital and one responsible for education and training) informed there is an orientation process provided that included a period of being buddied.

In all eight staff files reviewed (clinical manager, two registered nurses, three caregivers, activity therapist, cook) included reference checks and a record that an orientation had been completed.

The service has an internal training programme directed by head office. There is an assigned in-service training manual that includes sessions required at orientation and then yearly. Challenging behaviour and dementia are part of the training programme.

In addition to training requirements there are healthcare assistant competencies (hand washing, manual handling, restraint, first aid) with a tracking sheet in place to monitor requirements.

The 2013/2014 training programme exceeds eight hours of in-service training. Staff also attend relevant training sessions at aged concern in Whangarei.

D17.7d: RN competencies include: hand washing, manual handling, restraint, medication, CAPD, syringe driver. As for above a tracking process is in place to monitor requirements.

ARHSS D17.1: There are 21 healthcare assistants in the psychogeriatric unit. Seven of these have completed the required dementia standards and the other 14 have been at the service less than one year and are currently in the process of completing.

ARHSS D17.7 The activity therapist working in the PG unit has completed ACE dementia modules.

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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.2.7.4 (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.

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

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Acuity and clinical staffing ratio policy in place that includes a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. The facility manager and manager, both registered nurses work full time.

The six healthcare assistants (two psychogeriatric unit and four hospital/rest home) and four registered nurses (two psychogeriatric unit, two hospital/rest home) interviewed stated that there is adequate staffing to manage their workload on any shift.

There is a physiotherapist who works one morning a week.

The GP interviewed and confirmed that staffing is appropriate to meet the needs of residents.

Seven residents and seven relatives interviewed confirm that there are sufficient staff on site at all times.

There is 24/7 RN cover in the PG unit and 24/7 RN cover in the hospital/rest home.

The facility manager and clinical manager are both RNs and work full time.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and service register. These are paper based files.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Informed consent is obtained from residents/family/whanau on admission, for permission to display the resident's name and taking of photographs.

D7.1 Entries are legible, dated and signed by the relevant caregiver or RN including designation

Care plans and notes are legible and where necessary signed and dated. Policies contain service name. All resident records contain the name of resident and the person completing the form/entry.

Individual resident files kept demonstrate service integration that also contains GP notes and the allied health professionals and specialists records if applicable.

Communication with families is documented in the communication form and this was well used in the seven files reviewed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. NASC assessments are required for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the residents level of care requirements. There is a comprehensive information pack provided to all residents and their families for rest home, hospital and acute GP care. The pack includes all relevant aspects of service

delivery and residents and or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints information, advocacy, and admission agreement. Seven residents (three from the rest home and four from the hospital) and seven family members (two from the rest home, one from the hospital and four from the psychogeriatric unit) interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Seven resident files (two from the rest home, two from the hospital and three from the psychogeriatric unit), were reviewed. Seven had NASC approval and signed service agreements.

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

D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

There is a declining entry section in the admission procedure. The service records document the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy and process that describe resident's admission and assessment procedures.

A registered nurse undertakes the assessments on admission, with the initial support plan completed within 24 hours of admission.

Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. The care summary is reviewed as part of the regular resident review process (six monthly or sooner if needs change). Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

All seven files identified integration of allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. The GP interviewed spoke very positively about the service, especially since the change in management and describes improving communication processes (link 1.3.6.1 regarding GP not being informed of laboratory results).

D16.2, 3, 4: The seven resident files (two from the rest home, two from the hospital and three from the psychogeriatric unit), identified that in all seven files a nursing assessment was completed within 24 hours and six of seven files identify that the long term care plan was completed within three weeks. One psychogeriatric unit resident has not yet been at the service three weeks and the long term care plan is started but not completed. There is documented evidence that the care plan were reviewed by a RN and amended when current health changes (link 1.3.6.1). Five of seven care plans reviewed evidenced evaluations completed at least six monthly. Two residents had been in the facility less than six months.

ARHSS D16.6; Three residents with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviours in all three files were well identified through the assessment process, management plans implemented; short term care plans were developed for acute episodes of aggressive behaviour with evidence of regular evaluations.

Tracer Methodology rest home:

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

Tracer Methodology hospital:

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

Tracer Methodology psychogeriatric:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A comprehensive initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs outcomes and goals of residents are identified. A range of assessment tools are completed in resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. Nutrition and pain are assessed on admission and as needed and weights and BP's are monitored on a weekly to monthly basis dependant on needs. Assessments are conducted in an appropriate and private manner. All residents interviewed are satisfied with the support provided.

Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, handover sheets, progress notes, initial assessment and care plans. Seven residents (three from the rest home and four from the hospital) and seven family members (two from the rest home, one from the hospital and four from the psychogeriatric unit) stated they were informed and involved in the assessment process.

ARHSS D16.5gii: Three resident files reviewed from the psychogeriatric unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents' files include; initial assessment, daily progress notes, BP and weight recordings, short term care plans, long term care plans, risk assessments/nutrition, regular evaluations, GP initial assessment and visits, lab results, NASC assessment, allied health reports, activities, consents, advance directives, letters, referrals and archived notes.

Care plans are individually developed with the resident and family/whānau involvement is included where appropriate. All care plans reviewed were evidenced to be up to date. Goals and outcomes are identified and agreed and how care is to be delivered is explained.

Two of three psychogeriatric residents and two of two rest home residents have an individualised long term care plan that covers all areas of need identified (link 1.3.6.1). Areas covered in the seven resident files (two from the rest home, two from the hospital and three from the psychogeriatric unit) sampled include (but are not limited to): behaviour, social and emotional needs, cultural needs, falls risk, activities of daily living (ADL)'s, nutrition and social needs. Service delivery plans demonstrate service integration. Assessments and care plans are comprehensive and include input from allied health including district nurses, orthopaedics, oncology, DHB nurse specialist, physiotherapy and podiatry. There is evidence that residents are seen by their GP at least three monthly. The care plan format is comprehensive and goal oriented. Notes are well maintained. Significant events and communication with families are well documented.

D16.3k, ARHSS 16.3g: Short term care plans are in use for changes in health status.

D16.3f; ARHSS D16.5f Three psychogeriatric resident files reviewed identified that family were involved.

ARHSS 16.3g: Three psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All three residents had comprehensive behaviour management plans.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The service provides services for residents requiring rest home, hospital level care psychogeriatric level care.

Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans are evident. Care plans evidenced at least six monthly care plan reviews. The use of short term care plans are evident. The care being provided is consistent with the needs of residents, this is evidenced by discussions with six health care assistants (two who work in the psychogeriatric unit and four who work in the rest home/hospital) who work both am and pm shifts, seven family members (two from the rest home, one from the hospital and four from the psychogeriatric unit), four RN's (two from the rest home/hospital and two from the psychogeriatric unit), the clinical manager, registered nurse (RN) and the facility manager. Residents' needs are assessed prior to admission and resident's primary care is provided by their own GP.

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans are in place for five residents with wounds including two residents with pressure areas.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided.

ARHSS D16.4; There is good specialist input into residents in the PG unit. A Mental health consultant visits at least monthly, psychogeriatrician visits at least monthly and psychiatric district nurse visits at least weekly. Strategies for the provisions of a low stimulus environment could be described.

Shortfalls have been identified around documentation in resident files and 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:

The service provides services for residents requiring rest home, hospital level care psychogeriatric level care. Seven resident files were reviewed for this audit:

There is evidence of referrals to specialist services such as podiatry, physiotherapy, district nurses and gerontology nurse specialist. There is also evidence of community contact.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans are in place for five residents with wounds including two residents with pressure areas.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided.

ARHSS D16.4; There is good specialist input into residents in the PG unit. A Mental health consultant visits at least monthly, psychogeriatrician visits at least monthly and psychiatric district nurse visits from the POP's team at least weekly. Strategies for the provisions of a low stimulus environment could be described.

Finding:

(a)The following shortfalls are identified in residents files: (i) Resident 1) (psychogeriatric resident) Following an incident a resident was assessed as needing two staff for lifting in the shower. This is documented on the health care assistant handover sheet but the care plan has not been updated and still states: one person assist'. (ii) Resident 2) (rest home resident) The dietitian stated the resident should be weighed weekly. This has not occurred. (iii) Resident 3) (hospital resident) The care plan does not address XXXXXX The resident has had a sustained weight loss of one kilogram per month for the past eight months. There has been no dietitian referral and this has not been addressed in the care plan. The GP requested a follow up blood test in two weeks at the end of May 2014. This did not occur. When the GP identified this at the end of July 2014 the repeat blood test was completed. The result was a sub therapeutic level and the RN documented she had informed the GP. On 5 August 2014 the GP documented that she had not been informed of the result until that day. The GP confirmed during interview that she had not been informed of the blood test result. (iv) Resident 4) (hospital resident) The assessment indicates that staff should ensure the resident is fully alert and positioned upright before feeding her. Also she is to have sub cut fluids if fluid intake is below 1000 mls. These care interventions are not addressed in the care plan. The resident's two hourly turning chart also indicates that regular two hourly turns have not always occurred. (b) Two of five wounds have not always been reviewed within the stated timeframe.

Corrective Action:

(i)Ensure all identified needs are addressed in the care plan. (ii) Ensure that care plans are updated when needs change. (iii) Ensure that allied health professionals such as dietitian and GP instructions are followed. (iv) Ensure that abnormal laboratory results are communicated to the GP in appropriate timeframes. (ii) Ensure weight loss is appropriately addressed with dietitian referrals and care plan updates. (v) Ensure that two hourly turns occur regularly and that these are documented. (vi) Ensure that wounds are reviewed within stated time frames.

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

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

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

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

Attainment and Risk: FA

Evidence:

The activities coordinator employed by the service has works 40 hours over five days. A second activities coordinator who worked in the psychogeriatric unit has recently left and a new diversional therapist has been recruited for this position but has not yet commenced employment. In the interim the activities coordinator is providing activities in the psychogeriatric unit and a health care assistant (HCA) has been seconded to provide activities in the rest home/hospital. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and in the psychogeriatric unit lounge. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.

Activities are age appropriate and have been comprehensively planned. The psychogeriatric unit activities plan is developed by the activities coordinator (who has completed ACE dementia training and attends local diversional therapy meetings) and the facility manager (a registered nurse). Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, music/sing alongs, bingo movies and outings. There are also visits from community groups. There is a fortnightly shopping outing and a fortnightly morning tea or lunch outing on alternate weeks. The van is shared with another facility and is available four days one week and two the next. A group of four returned service men (two from the hospital and two from the psychogeriatric unit) and one other resident who enjoys pokie machines visit the RSA weekly.

All seven family members (two from the rest home, one from the hospital and four from the psychogeriatric unit), interviewed stated that activities are appropriate and varied enough for the residents. All seven residents (three from the rest home and four from the hospital) interviewed stated they were happy with the activities available and are given a choice regarding attendance.

D16.5d: Three of four resident files reviewed from the rest home and hospital identified that the individual activity plan is reviewed at the time of the care plan review. One rest home resident file viewed had been in the facility less than six months.

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered is included in the lifestyle care plan. Residents are quick to feedback likes and dislikes to the activity officer. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All initial care plans were developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status (link 1.3.6.1). There is a three monthly review by the GP. There was documented evidence that evaluations were up to date in all seven care plans reviewed. Overall changes in health status are documented and followed up (however, link improvements required 1.3.6.1). Care plan reviews are signed as completed by an RN. GP's review residents medication at least three monthly or when requested if issues arise or health status changes.

D16.4a Care plans are evaluated six monthly or 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 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

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

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

Attainment and Risk: FA

Evidence:

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

There is information available pre-admission and in the admission documentation on the health and disability code of rights, advocacy, health practitioners code of conduct and informed consent. Follow up occurs as appropriate.

D16.4c: The service provided an archived example of when a resident's condition had changed and the resident was reassessed for a higher level of care. Currently no residents are awaiting a NASC reassessment.

D 20.1: Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, district nurses, podiatrist and physiotherapy services.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of which is kept on the resident's file. This was sighted in three resident files transferred to hospital. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are policies and processes that describe medication management that align with accepted guidelines. Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.

Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member.

Resident medication charts are identified with demographic details and photographs. The fridges that medications are kept in has a weekly temperature check. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal. Allergies are identified on the medication records. All 14 medication charts had allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms.

There is a locked cupboard that is used for controlled drugs in each wing. There are drug trolleys that are kept in the treatment room in each wing which are locked when not in use.

Medication round observed in the hospital/rest home; all practice is appropriate.

A medication competency has been completed annually by all staff who administer medication.

There is a policy and process that describes self-administered medicines. There are currently no residents who self-administer medication.

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

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.3.12.3 (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.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

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

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

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs one kitchen hand, one assistant chef, one casual cook and two kitchen hands provide meal services over seven days a week. There is a rotating four weekly menu in place that was designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. An RN completes each resident's nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen

Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.

The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that they are asked by staff about their food preferences. Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch.

The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. Fridge/freezer temperatures are checked daily. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away.

Food audits are carried out as per the yearly audit schedule.

ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours.

D19.2: Kitchen staff have been trained in safe food handling.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident / accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency manual available to staff which includes hazardous substances. Six health care assistants, four RN's, one clinical manager and one facility manager interviewed were able to describe hazard management.

There is an emergency plan to respond to significant waste or hazardous substance management. Waste management/chemical training occurs annually.

All chemicals sighted were appropriately stored in locked areas. Chemicals are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The building holds a current warrant of fitness which expires on 1 June 2015. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed the facility manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. The maintenance person is available on an on call basis. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees. Hoists were serviced last in July 2014 and medical equipment was calibrated in September 2013.

The facility's amenities, fixtures, equipment and furniture are appropriate for rest home, hospital and psychogeriatric care residents. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Resident's bedrooms throughout the facility have resident's own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained.

The hospital rest home rooms are all dual-purpose and this can be managed safely by the service.

The service is planning on extending the psychogeriatric unit by converting three previously hospital/rest home bedrooms into the psychogeriatric wing. This will involve changing a wall in a disused room at the end of the current psychogeriatric unit to extend the hall into the end of the three bed wing and placing a wall at the other end of that wing to secure the unit. The three resident rooms are large in size and the wing includes a mobility accessible toilet and shower.

ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids. Interviews with two healthcare assistants from the psychogeriatric unit confirmed there was adequate equipment.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All wings have access to adequate numbers of toilets and showers. One bathroom is able to cater for the shower trolley used at the service. Communal toilets have adequate signage. Visitor/staff toilets are well signed. Hand basins are located in all service areas. All toilets have access to hand basins and adequate hand drying facilities. Hand sanitizer gel is provided throughout the facility. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The floor coverings are carpet and vinyl. The facility was clean and well presented.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is adequate space in all bedrooms for residents and staff. Six healthcare assistants were asked if there was sufficient room and they confirmed they were able to move freely to provide cares. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Seven residents (three from the rest home and four from the hospital) are happy with their rooms.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

The service has a main lounge and open plan dining area in both the rest home/hospital and the psychogeriatric unit. There are smaller lounge areas within the facility and also a second dining area in the psychogeriatric unit. Residents were seen to be moving freely throughout facility in wheel chairs and walking frames. Residents are able to move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements and give wheelchair access. Activities occur in

the main lounges and residents are able to access their rooms for privacy when required. Seven residents (three from the rest home, four from the hospital) are happy with the communal areas.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are cleaning policies and processes. Cleaning audits occur. Corrective actions required are followed through the quality/risk management and staff meetings. The cleaning room is a designated area and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. All laundry is completed off site.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence box is available (sighted). The facility manager stated that they have spare blankets and alternative cooking methods if required (viewed). There is sufficient water stored in bottles to ensure for three litres per day for three days per resident.

The staffing level provided adequate numbers of staff to facilitate safe care to rest home, hospital level. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 20 March 1997. Fire drills have occurred six monthly, last on 13 June 2014, 26 June 2014 and 29 June 2014. The drill was repeated after shortfalls were identified with a satisfactory and improved result from the last drill.

There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

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

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

General living areas and resident rooms are appropriately heated and ventilated. The facility has heating that is thermostatically controlled. All bedrooms and communal areas have at least one external window.

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint Minimisation and safe practice policy & procedure includes; a) definitions, b) Use of restraint is a last resort only, c) methods of restraint permitted within Radius, d) use of enablers, e) enablers permitted with radius, f) client rights, g) assessment, discussion & restraint alternatives, h) restraint alternatives are not effective, i) restraint care, j) monitoring and removal, k) restraint episode evaluation, l) risks associated with restraint, m) restraint coordinator, n) staff training, o) restraint meetings, and p) maintenance.

Related forms include: restraint assessment, discussion and alternatives form; restraint discussion and consent form; restraint monitoring form; enabler assessment and consent form; restraint register; enabler register; care plan for client requiring restraint; restraint episode evaluation form.

The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.

There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.

There is one resident with an enabler in the form of bedrails in the hospital. A consent and two hourly monitoring is in place.

The restraint minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whanau, development of an enabler care plan, monitoring, reduction, removal and evaluation of enablers.

The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of the file of the resident with an enabler.

There are four residents in the hospital with restraint (all bedrails). Intermittent lap belt restraints are used for five residents in the psychogeriatric (PG) unit.

ARHSS D16.6: There is a managing disturbed behaviour policy.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least monthly at Rimu Park and as part of the register monthly restraint meeting and regular multidisciplinary review that involves family/whanau. This had occurred for the two restraint files reviewed for residents requiring PRN lap belts.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. All assessments are reviewed by the clinical manager (the restraint coordinator) as sighted in the two files sampled for residents who use PRN restraints.

Assessments are completed as required for individual residents. The two files sampled identified that a restraint assessment, discussion and alternatives form and restraint discussion and consent form were completed for the two residents requiring restraint.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The restraint team includes the restraint co-ordinator who is the clinical manager. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. There are approved restraints documented in the policy.

The approval process includes ensuring the environment is appropriate and safe. Approval for each individual resident is reviewed monthly at the restraint meetings.

The restraint assessment identifies specific interventions or strategies to try (as appropriate) before using restraint. The care plans for the two residents reviewed at de-escalation strategies and a clear process for the use of lap belts as a last resort.

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and its outcome that aligns with a) - g) in this criterion. Restraint monitoring forms include type of restraint used, risks associated with type of restraint, times restraint on/off, toileting, wheelchair lap belt use and repositioning of a resident when in bed. Forms include assessment, monitoring, risks, consent and alternatives to restraint.

Two restraint files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. Monitoring forms were completed. A monthly evaluation of restraint was completed.

The service has a restraint register and monitoring forms that records sufficient information to provide an auditable record of restraint use.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The files reviewed of residents requiring restraint have been evaluated monthly. Family/whanau participate in evaluations and also at the residents' multidisciplinary review. Use of restraint is discussed at monthly restraint meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k).

Restraint practices are reviewed on a formal basis in the staff meetings and quality meetings. A restraint evaluation is completed of the restraint care plan three monthly. Evaluation timeframes are determined by risk levels. Family/whanau is involved in review at residents' annual multidisciplinary review.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Approved restraint for each individual is reviewed at least monthly by the restraint approval group and as part of the annual multidisciplinary review with family/whanau involvement.

Restraint usage across the facility is monitored monthly and it is discussed at monthly restraint, quality and RN meetings. Restraint usage is also benchmarked across the organisation and is reviewed at the organisational level.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme - IC surveillance audit was last undertaken in March 2014 (100% compliance). The service submits data monthly to Radius head office where benchmarking is completed.

The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the quality meetings and also to RN meetings and HCA meetings where appropriate. Monthly data was seen in the staff room. The service had a scabies outbreak March in the PG unit (11 confirmed). This was well managed including involvement with public health. No further outbreaks of scabies have been reported since March. Scabies information hand-outs were also provided to staff during this time.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The IC coordinator (enrolled nurse) collates monitoring data and reports through to the quality meetings. Outcomes are reported to staff through RN meetings and HCA meetings. The IC Coordinator receives on-going education through the local aged concern training sessions and she has also attended a bug control course. In the event of the IC coordinator requiring advice this is available through the GP, Pathlab or Bug Control.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. Policies include; antimicrobial guidelines, decontamination, food handlers sickness policy, hand hygiene, management of staff with communicable diseases, MRO, outbreak management, pandemic plan, respiratory hygiene, scabies management, single use items, transmission based precautions, UTIs, waste management, . Associated policies include wound management policy, continence policy, laundry and kitchen policies. There are comprehensive Infection Control policies that support the Infection Control Standard SNZ HB 8134:2008. The infection control policies link to other documentation and uses references where appropriate.

Infection control policies are reviewed as part of the policy review process by Radius input is sought form facilities when reviewing policies.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The IC coordinator has completed a Bug Control course. The IC coordinator ensures training is provided to staff. Informal education is also provided - availability of education was confirmed by healthcare assistants interviewed.

The orientation package includes specific training around hand washing and standard precautions. Training on infection control was last provided in May and October 2013 and is scheduled for 2014. Hand washing is an annual competency.

Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and internal (process) monitoring is undertaken via the internal audit programme.

The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory and skin. This data is reported to the quality meetings and also to RN meetings and HCA meetings where relevant. Monthly data was seen in the staff room.

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

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p> <p>Corrective Action:</p> <p>Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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

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