Rangiura Trust Board

Current Status: 28 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

Rangiura Home provides rest home, hospital and specialist dementia level of care for up to 72 residents. This includes a 20 bed specialist secure dementia unit, Fern Haven House, which has gained national and internal recognition for its environment that reflects the services Eden Alternative approach to care and service delivery. At the time of audit there were 69 residents (33 rest home, 19 hospital and 17 in Fern Haven). There were two younger residents that are under the age of 65.

There are no areas requiring improvement identified at this audit. There are a number of areas that have received a continuous improvement rating (an excellence rating beyond the standard normally expected) for the risk and quality systems, ongoing education, care planning, restraint minimisation and the implementation of services delivery which reflects the Eden Alternative and the environment of Fern Haven.

Audit Summary as at 28 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 28 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.

Organisational Management as at 28 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.		Standards applicable to this service fully attained.

Continuum of Service Delivery as at 28 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.		Standards applicable to this service fully attained.

Safe and Appropriate Environment as at 28 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.		All standards applicable to this service fully attained with some standards exceeded.

Restraint Minimisation and Safe Practice as at 28 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.

Infection Prevention and Control as at 28 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.

Audit Results as at 28 August 2014

Consumer Rights

The service has processes in place that demonstrate their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents in the rest home, hospital and specialist secure dementia sections are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural choices, values and beliefs are practiced at the service.

Residents receive services of an appropriate standard for the hospital, rest home and specialist dementia level of care. The service provides an environment that encourages good practice reflective of the Eden Alternative.

Staff communicate effectively with residents and provide an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff is demonstrated. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified and embrace the 'Eden Alternative'. The 'Eden alternative is an approach to care that ensures residents are living in a human habitat that is meaningful to the residents.

Rangiura is operated by a community trust board. There is a full board, an executive committee and the facility management team. The service is managed by an appropriately experienced and qualified management team who are responsible for the overall day to day operations of the service. The chief executive officer, general manager and clinical nurse manager are supported by an administration and clinical team.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The service has conducted a number of quality and risk management improvements which exceed the full attainment rating and have gained a continuous improvement rating, beyond what the standard normally expects, for the ongoing implementation of the quality improvements at the service.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There are established processes for the orientation of new staff members. The education programme is available for all staff and education records are well maintained. The staff who work in the secure dementia unit have the required specialist national qualifications in the provision of dementia care, the ongoing education has also rated beyond what the standard normally expects.

There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of hospital, rest home and specialist dementia levels of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board.

Continuum of Service Delivery

The service implements the organisations policies and procedures and processes related to entry into the service and the continuum of service delivery. Services are provided by suitably qualified and trained staff to meet the needs of the residents. The service has robust systems in place to assess, plan, review and evaluate the care needs of each resident. The physiotherapist assessments and registered nurse assessments are comprehensive and form the basis of care planning.

The GP and/or the nurse practitioner visit the facility on a regular basis. A team approach to care is provided to ensure continuity of care is maintained.

The service has planned activities programmes to meet the recreational requirements of residents. Residents are encouraged to maintain links with family and the community. The dementia service has activities planned for the 24 hour period.

A timely medicine management system is observed. The medicine management process and procedures comply with legislation and guidelines are available. The staff responsible for medication management have completed medication competencies and evidence is clearly documented.

Residents` nutritional requirements are met by the service. As confirmed during interviews with residents, likes, dislikes and special diets are well catered for.

There are two continuous improvements in relation to service delivery care planning and the assessment processes in conjunction with the Eden Alternative Philosophy implemented across all areas of the service.

Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and secure dementia level of care. The service ensures physical privacy is maintained, has adequate space and amenities to facilitate independence and is in a setting appropriate to the needs of both younger and older people at the service. Residents, visitors, and staff are protected from harm as a result of exposure to waste and infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

Residents are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. The facilities for the residents living in the Fern Haven House dementia unit provide a safe and secure environment for residents to wander freely. The environment of Fern Haven has gained national and international recognition for implementing the Eden Alternative, which exceeds what the standard normally expects, and have gained a continuous improvement rating for the built environment.

All buildings, plant, and equipment comply with legislation. There is an ongoing refurbishment and maintenance schedule. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained. The facility has an appropriate call system for residents to request assistance from staff. The building has a current building warrant of fitness. Residents have access to gardens and courtyards. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Residents are provided with adequate toilet/shower/bathing facilities. The rooms in the Fern Haven House have ensuites. The rest home and hospital sections have ensuites or access to shared toilet and shower facilities. There are shared facilities conveniently located throughout the service. Residents are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Restraint Minimisation and Safe Practice

Rangiura rest home, hospital and dementia unit has policies and procedures implemented to ensure the safe use of restraints and enablers. Staff education is undertaken as part of the orientation process and is ongoing. Staff are able to demonstrate their understanding of the restraint minimisation and safe practice policy and procedures and the definition of an enabler. The service follows the restraint approval, assessment, evaluation, monitoring and quality review processes.

There are two areas identified as continuous improvements for restraint minimisation and safe practice in relation to restraint approval processes in place and restraint monitoring and restraint review systems utilised .

Infection Prevention and Control

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. The infection control programme is reviewed annually. The organisations infection prevention and control policies and procedures are developed which reflect current accepted good practice. Relevant education is provided for both staff and residents. There is a monthly surveillance programme where infections are recorded, analysed, and where trends are identified, actions are implemented to reduce infections.

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:	Rangiura Trust Board
Certificate name:	Rangiura Trust Board

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Certification Audit			
Premises audited:	Rangiura Rest Home & Retirement Village			
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	28 August 2014	**End date:**	29 August 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	69

Audit Team

Lead Auditor	XXXXX	**Hours on site**	12	**Hours off site**	8
Other Auditors	XXXXX	**Total hours on site**	12	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	3

Sample Totals

Total audit hours on site	24	Total audit hours off site	15	Total audit hours	39

Number of residents interviewed	9	Number of staff interviewed	19	Number of managers interviewed	3
Number of residents' records reviewed	9	Number of staff records reviewed	11	Total number of managers (headcount)	4
Number of medication records reviewed	18	Total number of staff (headcount)	104	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	0

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Friday, 5 September 2014

Executive Summary of Audit

General Overview

Rangiura Home provides rest home, hospital and specialist dementia level of care for up to 72 residents. This includes a 20 bed specialist secure dementia unit, Fern Haven House, which has gained national and internal recognition for its environment that reflects the services Eden Alternative approach to care and service delivery. At the time of audit there were 69 residents (33 rest home, 19 hospital and 17 in Fern Haven. There were two younger residents that are under the age of 65.

There are no areas requiring improvement identified at this audit. There are a number of areas that have received a continuous improvement rating (an excellence rating beyond the standard normally expected) for the risk and quality systems, ongoing education, care planning, restraint minimisation and the implementation of services delivery which reflects the Eden Alternative and the environment of Fern Haven.

Outcome 1.1: Consumer Rights

The service has processes in place that demonstrates their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents in the rest home, hospital and specialist secure dementia sections are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural choices, values and beliefs are practiced at the service.

Residents receive services of an appropriate standard for the hospital, rest home and specialist dementia level of care. The service provides an environment that encourages good practice reflective of the Eden Alternative.

Staff communicate effectively with residents and provide an environment that is conducive to effective communication. The residents and their families/whanau right to full and frank information and open disclosure from the staff is demonstrated. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

Outcome 1.2: Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified and embrace the 'Eden Alternative'. The 'Eden alternative is an approach to care that ensures residents are living in a human habitat that is meaningful to the residents.

Rangiura is operated by a community trust board. There is a full board, an executive committee and the facility management team. The service is managed by an appropriately experienced and qualified management team who are responsible for the overall day to day operations of the service. The chief executive officer, general manager and clinical nurse manager are supported by an administration and clinical team.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The service has conducted a number of quality and risk management improvements which exceed the full attainment rating and have gained a continuous improvement rating, beyond what the standard normally expects, for the ongoing implementation of the quality improvements at the service.

The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There are established processes for the orientation of new staff members. The education programme is available for all staff and education records are well maintained. The staff who work in the secure dementia unit have the required specialist national qualifications in the provision of dementia care, the ongoing education has also rated beyond what the standard normally expects.

There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of hospital, rest home and specialist dementia levels of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board.

Outcome 1.3: Continuum of Service Delivery

The service implements the organisations policies and procedures and processes related to entry into the service and the continuum of service delivery. Services are provided by suitably qualified and trained staff to meet the needs of the residents. The service has robust systems in place to assess, plan, review and evaluate the care needs of each resident. The physiotherapist assessments and registered nurse assessments are comprehensive and form the basis of care planning.

The GP and/or the nurse practitioner visit the facility on a regular basis. A team approach to care is provided to ensure continuity of care is maintained.

The service has planned activities programmes to meet the recreational requirements of residents. Residents are encouraged to maintain links with family and the community. The dementia service has activities planned for the 24 hour period.

A timely medicine management system is observed. The medicine management process and procedures comply with legislation and guidelines are available. The staff responsible for medication management have completed medication competencies and evidence is clearly documented.

Residents` nutritional requirements are met by the service. As confirmed during interviews with residents, likes, dislikes and special diets are well catered for.

There are two continuous improvements in relation to service delivery care planning and the assessment processes in conjunction with the Eden Alternative Philosophy implemented across all areas of the service.

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and secure dementia level of care. The service ensures physical privacy is maintained, has adequate space and amenities to facilitate independence and is in a setting appropriate to the needs of both younger and older people at the service. Residents, visitors, and staff are protected from harm as a result of exposure to waste and infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

Residents are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. The facilities for the residents living in the Fern Haven House dementia unit provide a safe and secure environment for residents to wander freely. The environment of Fern Haven has gained national and international recognition for implementing the Eden Alternative, which exceeds what the standard normally expects, and have gained a continuous improvement rating for the built environment.

All buildings, plant, and equipment comply with legislation. There is an ongoing refurbishment and maintenance schedule. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.

The facility has an appropriate call system for residents to request assistance from staff. The building has a current building warrant of fitness. Residents have access to gardens and courtyards. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Residents are provided with adequate toilet/shower/bathing facilities. The rooms in the Fern Haven House have ensuites. The rest home and hospital sections have ensuites or access to shared toilet and shower facilities. There are shared facilities conveniently located throughout the service. Residents are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Outcome 2: Restraint Minimisation and Safe Practice

Rangiura rest home, hospital and dementia unit has policies and procedures implemented to ensure the safe use of restraints and enablers. Staff education is undertaken as part of the orientation process and is ongoing. Staff are able to demonstrate their understanding of the restraint minimisation and safe practice policy and procedures and the definition of an enabler. The service follows the restraint approval, assessment, evaluation, monitoring and quality review processes.

There are two areas identified as continuous improvements for restraint minimisation and safe practice in relation to restraint approval processes in place and restraint monitoring and restraint review systems utilised .

Outcome 3: Infection Prevention and Control

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. The infection control programme is reviewed annually. The organisations infection prevention and control policies and procedures are developed which reflect current accepted good practice. Relevant education is provided for both staff and residents. There is a monthly surveillance programme where infections are recorded, analysed, and where trends are identified, actions are implemented to reduce infections.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	1	49	0	0	0	0	0
Criteria	7	93	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	1

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	CI	There is evidence from the review of a number of quality improvement projects that the quality and risk systems are continually reviewed, evaluated and improved. The service has gained recognition for becoming the first Australasian centre for the implementation of the Eden Alternative in the built environment of the Fern Haven House dementia facility. The organisation can demonstrate a number of innovative programmes that have impacted positively

Code	Name	Description	Attainment	Finding
				on the safety and satisfaction of residents. Staff at all levels of the organisation are involved in the implementation of the quality improvement projects.
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	The system to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to residents is rated beyond the full attainment. The ongoing education that is provided exceeds the requirements set out by the district health board. An analysis of the education and professional development occurs through the operational reports. These reports show the range and investment in staff education and ongoing training that has been implemented. The implementation of the ongoing education programme is providing positive outcomes in resident safety (for example reduction of injuries) and high resident and family satisfaction in the quality of the care provided.
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	CI	A continuous improvement rating is made for the high standard of documentation into the individual momentum care plans and input acknowledged from staff involved in the personalised care and management of the individual residents at this rest home, hospital and dementia services. Interventions are discussed as to what is best for each individual resident not what is expected in relation to meeting goals set by the individual residents themselves.
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	CI	Having fully attained the criterion the service can in addition clearly demonstrate the high standard of documentation into the InterRAI assessment process. The process is comprehensive and along with the pre-admission assessment and the physiotherapy functional assessment (inclusive of falls risk and manual handling assessments) is readily available and accessible when developing the Momentum InterRAI care plans and is improving the service delivery for all residents in all services.
HDS(C)S.2008	Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	CI	
HDS(C)S.2008	Criterion 1.4.5.1	Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.	CI	The achievement of providing residents with a safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs of residents with cognitive impairment is beyond the expected full attainment. Fern Haven House has gained national and international recognition as an environment to meet the needs of resident's living with dementia. Rangiura have conducted a review process which includes analysis and reporting of findings to staff, residents, relatives, national conferences and international conferences. There is evidence of action taken to implement the Eden

Code	Name	Description	Attainment	Finding
				'Greenhouse Memory Support Home' which has resulted in improvement to service provision for residents and family/family in Fern Haven. The resident and family/whanau satisfaction has been measured through resident/family and Eden satisfaction surveys, which evidence improved outcomes for resident's.
HDS(RMSP)S.2008	Criterion 2.2.2.1	In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.	CI	Having fully attained the criterion the service can in addition clearly demonstrate the high standard of restraint management documentation reviewed. The assessment process is fully undertaken by the restraint co-ordinator. A very experienced physiotherapist employed by this service for 14 years. The restraint co-ordinator interviewed fully comprehends the restraint minimisation standard and has developed and implemented with approval from management a complete restraint management package which is fully and clearly utilised for each individual resident who may require to use a form of restraint and/or an enabler. This has improved the restraint management for residents using restraint by ensuring all the needs of the residents are effectively met whilst a restraint is in place.
HDS(RMSP)S.2008	Criterion 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;	CI	Having fully attained the criterion the service can in addition clearly demonstrate excellence for restraint monitoring and quality review. The comprehensive quality review of individual restraint use performed six monthly or more often if required is well implemented by the experienced restraint co-ordinator. The audit criteria reviewed includes the review of the policies and procedures ensuring compliance with the Restraint Minimisation and Safe Practice Standard NZ8141 2008.

Code	Name	Description	Attainment	Finding
		(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.		An individual assessment and planned approach is delivered and followed that complies with the service policies and procedures. The audit evidences, timely and appropriate ongoing resident/family/whanau communication. This is clearly verified in the progress records and on the communication family record in the front of the resident`s files sighted. Advocacy, support and cultural needs are verified and provided, written consent is obtained and forms are signed appropriately. Safety is paramount.

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:

The resident right policy states 'it is our policy to ensure that resident's rights are under no circumstances breached and that residents and health care assistants (HCA)s understand the rights and the importance of them. To treat all residents equal and with a strong sense of empathy, dignity and regard to individual rights needs and wishes without discriminating against race, religious or sexual beliefs'. The policy notes the Code of Health and Disability Services Consumers Rights (the Code) is displayed and available to all residents and monitored to ensure the rights of residents are respected. New Residents are given a copy of the Code on admission and a copy is displayed on the wall in full view for residents, staff and visitors. The policy summarises the resident's rights, the code of ethics, the staff code of ethics, and requirements to maintain confidentiality and privacy

As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. The staff knock on doors before entering resident bedrooms, use residents' preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews (19 staff from across all areas, including registered nurses (RNs), health care assistants (HCAs), activities, domestic services and kitchen service) confirm they respect the resident's right to refuse cares or interventions. Staff can verbalise ways they deal with situations that arise which ensures residents' rights are maintained. This is confirmed during interviews with nine of nine residents (six rest home and three hospital) and four of four family/whānau members (includes families of residents living in the dementia unit).

The District Health Board (DHB) contract requirements are met.

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:

Opportunities are provided for explanations, discussion, and clarification about the Code of Health and Disability Services Consumers Rights (the Code) with the resident, family/whānau as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service is clearly displayed at the entrance to the facility and available to residents and visitors. Staff education on the Code and Advocacy services is conducted as part of the ongoing education programme. Interviews with nine of nine residents and four of four family/whānau report they are informed of their rights and that staff always respect all aspects of their rights. The service has a resident representative committee that consults with management and act as advocates for the residents. Three of the resident representatives interviewed report that a high quality of care is provided at Rangiura.

The DHB contract requirements are met.

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:

Policy provides guidance for staff on reporting, investigating and management of suspected episodes of physical abuse, sexual abuse, psychosocial abuse, institutional abuse, financial abuse, neglect, exploitation, discrimination and violation of client rights. Possible signs and symptoms are noted. The organisations responsibilities for the protection of vulnerable adults is noted. Another policy notes as the objective 'to maximise the resident's independence and promote personal individuality'. How staff can facilitate this is noted. Upholding the resident's right of choice is included.

Other policies detail how resident's personal privacy and dignity is to be maintained. This includes ensuring physical privacy during cares, allowing privacy during conversations (including via telephone), respecting residents personal property, the privacy to maintain friendships and respecting residents rights of individual choice.

As observed at the time of audit, the environment allows residents physical, visual, auditory and personal privacy. All rooms in the rest home and hospital sections are single occupancy. There are three rooms in Fern Haven House (the specialist dementia unit) that can be used as double rooms (for example with couples), though all of these rooms are single occupancy at the time of audit. Discussions with three registered nurses (RN)s and four family/whānau members confirms that there are many areas available for residents and family/whānau to talk in private.

Resident's needs, values and beliefs, including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in the nine of nine resident files reviews (three rest home, three hospital and three dementia) which identify interventions put in place to meet the identified needs.

As observed at the time of audit services are provided in a manner that maximises each resident's independence and allows choices to be respected. Residents and family/whānau report that they are treated with respect and that residents receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. This finding is confirmed during 10 care staff interviews (three (RN)s and seven (HCAs), resident and family interviews and the sighted responses from the resident satisfaction survey results.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)
Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)
Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA

Evidence:

The Maori health strategic plan/guidelines notes that residents who identify as Maori have their health and disability needs met in a manner that respects and acknowledges their individual values and beliefs.

Consultation occurs with

-Maori Advisors at our local DHB[s].

-Maori health providers in the community (RUAKAWA TRUST BOARD).

-Kaumatua and Kuia on local Marae. RUAPEKA MARAE (TA PAPA).

-Referral Agencies.

-Maori advocacy groups.

-Any residential care facilities established specifically for Maori.

-Local Schools of Nursing (WINTEC and WAIARIKI.)

-Maori Ministers and church groups.

-The resident and their whanau.

Barriers for Maori entering care, staff training, and process for accessing whanau support, identifying cultural needs of Maori on admission and during ongoing care are included in the consultation processes. A commitment to the Treaty of Waitangi (TOW), four cornerstones of Maori health and the components of the plan are documented. There is a template to document an assessment plan for Maori residents. The 'guidelines for the provision of culturally safe services for Maori' provides guidance for staff on the provision of culturally appropriate care and how staff can incorporate these identified principals into the provision of care/services.

The clinical nurse manager reports that there are no known barriers to Maori accessing the service. At the time of audit there are three residents who identify as Maori. Two of these residents interviewed report satisfaction with the culturally appropriateness of the care that is provided. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with the three RNs and seven HCAs. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. Cultural education, which includes Maori beliefs, is conducted as part of the ongoing education programme (sighted).

The DHB contract requirements are met.

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:

The client rights policy states ‘we recognise that every resident is an individual and as such has different needs in relation to ethnicity, spirituality, disability, gender, sexual orientation, social status and age. Where possible our home aims to meet these individual needs and incorporate them into daily routine without compromising the comfort or safety of other residents or staff.’

An assessment is completed for each resident and includes religious and value beliefs being identified in conjunction with the family/whanau (if appropriate), and recorded in the residents care plan. The diversional therapist also completes a resident profile which takes into account specific cultural and religious values and beliefs to assist with planning of activities that will be of interest and lead us to prevent loneliness, helplessness and boredom from their lives. The policy notes residents will be assisted to attend the Marae and church services are held on site. The Eden Philosophy of care is noted as being implemented.

The Eden philosophy of care is verified as being embedded into practice at Rangiura. Interviews with nine of nine residents and four of four family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. Family/whānau are involved in the development and review of the care plan (as sighted in nine resident file reviews).

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

There is a staff code of ethics and the behaviours expected by staff is clearly identified in assorted policies sighted. The 11 staff record reviews identify that staff sign a code of conduct that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with 19 staff (three RNs, seven HCAs, one physiotherapist, two activities coordinator, two cleaning, two laundry and two kitchen staff), nine residents, one nurse practitioner, and four family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation at the service.

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:

Interviews with three RNs and seven HCAs, one physiotherapist and one nurse practitioner confirm that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. The GP and nurse practitioner (NP) visit regularly and the service has established links with other local health services, the DHB and hospice for ongoing education and support.

There is regular in-service education and staff access external education that is focused on aged care such as care planning, specific medical conditions, wound management, palliative care and dementia care. All educational material sighted is evidenced to current best practice or evidenced based practice. The service has gained international recognition for the implementation of the 'Eden Alternative' (also see 1.2.1 and 1.2.7.5).

Interviews with nine of nine residents and four of four family/whānau members confirms their high level of satisfaction with all care delivery and staff attitude. The results of the annual resident /family satisfaction survey (conducted in November 2013) and the Eden Alternative satisfaction surveys record high satisfaction with the overall care and services provided at the service.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The open disclosure policy details the resident's right to open disclosure, the definition of open disclosure and how open disclosure is to occur. The timeframes for which open disclosure is to occur is detailed. Open transparent communication with the resident and or next of kin is detailed.

The 'interpretation and translation services policy' notes residents have the right to communication in a manner they understand. If interpreter services are required they can be accessed through the DHB. Only trained interpreters will be used with staff as a last resort

Policy related to open disclosure is implemented by the service. Interviews with four of four family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family communication is clearly documented in the nine resident file reviews and as appropriate on incident and accident forms sighted.

Wherever necessary and reasonably practicable, interpreter services are provided. The service has a number of residents from Dutch backgrounds and have staff who can communicate in Dutch. These residents are also able to communicate effectively in English.

The DHB contract requirements are met.

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:

The informed consent policy includes guidance on informed consent, what consents are required and the resident's right to refuse or withdraw consent. A template consent form includes storage and use of information general care/treatment, participation in outings/being transported, photographs for identification purposes, sharing of information

with family member(s). Nine of nine resident files reviewed demonstrated consent forms have been signed and dated appropriately. Senior staff receive training on the legislative requirements of informed consent. A list of legislative requirements is listed in the quality manual for this service.

Informed consent information is available for enabling decisions to be made by the resident or the family/whanau. Code of rights is available and interpreter services can be arranged if and when required and additional formats can also be arranged for example the enlargement of documents for the poorly sighted to ensure effective communication needs can be met.

Resident residential service agreements signed and dated on admission are evident in each of the nine of nine resident files reviewed. Any advanced directives are placed in the individual resident`s file on admission and are reviewed during the multidisciplinary review process.

All residents are regarded as being “for resuscitation” unless an explicit decision has been made in advance by resident only. If in doubt, resuscitate. All residents requesting not for resuscitation (NFR) status must be given a copy of the information sheet and a senior staff member should be available to discuss this with the resident. If a competent resident makes a free and informed request not to be resuscitated, the request must be documented by the resident and added to the resident’s records. It is RRH practice to have the resident’s GP sign to state that the resident was competent when signing the NFR authorisation. The process for documenting advanced directives or a living will is also noted in policy. The various policies include responsibilities of enduring power of attorney (EPOA) and activation process for EPOA.

Dementia service: The residents in this specialised dementia service are unable to sign the required documents themselves for example for consenting to the influenza vaccination, transportation for van outings as part of the activities programme. The GP has signed on the three of three resident files reviewed that they are unable to make these decisions. There is evidence of the family/whanau/representative EPOA input in files sighted.

The DHB requirements are met.

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.)*

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:

The nine of nine resident file reviews and interviews with nine of nine residents and four of four family/whānau members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family/whānau is encouraged to involve themselves as advocates. There are resident representatives who act as advocates for other residents and regularly consult with staff and management. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility. Family/whānau members confirm their awareness of where to locate the information.

The DHB contract requirements are met.

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:

Interviews with nine of nine residents confirm they have access to visitors of their choice. The four of four family/whānau interviews confirms that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.

Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. The service also has a hall that is used for committee groups and community events, that the residents can participate in. Documentation sighted in nine of nine residents' files identifies that regular community outings occur, the frequency which residents go out with friends and family and the community services who visit the facility. For example church services, school visits and external entertainment. Residents are welcome to have their own spiritual advisor visit or to attended services in the community. On the days of audit it is observed that residents went out to partake in community and family activities. One of the younger residents (under the age of 65) reports that their independence is encouraged and they regularly walk into town'.

The DHB contract requirements are met.

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 sighted complies with Right 10 of the Code. All complaints are handled in a professional manner by the manager of appropriately designated person. They are facilitated and resolved in a fair, simple and efficient way. Everybody has the right to complain, which can be in writing or verbal, and complaints can also be made anonymously, although this means that these cannot be responded to individually.

The service has an up-to-date complaints register which identifies the date of the complaint, the complainant, description of the issue, the actions taken, if advocacy process has commenced and the outcome/close of the complaint. There are no outstanding complaints regarding the service at the time of audit. There is one complaint recorded to date in 2014, with the complaint investigation occurring within the time frames of Right 10 of the Code.

The nine of nine residents and four of four family/whanau interviews confirm they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. The information given to all residents and family/whanau upon admission includes complaints forms and a full explanation of how the system works. This information on making a complaint or providing feedback is in the residents welcome booklet. Advocacy information is also included in the admission booklet. Both complaints and advocacy information is on full display at the entrances to the facility.

Interviews with the staff confirm awareness of their responsibility to record and report any complaints they may receive. Interviews with three members of the resident committee report that residents feel free to lodge a complaint and there is ‘no fear’ of making a complaint.

The DHB contract requirements are met.

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:

The mission statement and philosophy/values are documented in the 2014/2015 Rangiura Trust Board objectives and quality improvement plan.

Mission statement is 'Providing a home environment where our residents continue to grow and live with the dignity and respect they deserve in an encouraging and cheerful environment. To be cared for at all times by competent and committed staff who will provide ongoing holistic care- appropriate to our resident's social, spiritual, cultural and recreational needs.'

Home Philosophy-Vision

To embrace the philosophies of the Eden Alternative, to help ensure our residents are living in a humane habitat that encourages continued growth and purpose by;

Excelling in all aspects of care of the elders committed to us by creating and nurturing a team of dedicated, proactive and professional staff

Providing our elders with ongoing opportunities for meaningful activity and responsibilities, loving companionship, spontaneity, and variety

Respecting and nurturing our elders, their families and, one another

Becoming the elder's friends, advocates and confidants

Protecting the individuality and privacy of our elders

Listening and responding with care

Innovating and continually refining our services so that they fulfil the needs of those we care for.

The service incorporates the person centred care approach of the 'Eden Alternative' into their mission and philosophy. 'By combating loneliness, helplessness and boredom we reduce most of the suffering experienced by our elders or residents in Aged Care, through the Eden Alternative.' The 10 principle are:

"i.The three plagues of loneliness, helplessness and boredom account for the bulk of suffering among our Elders.

ii. An Elder-centred community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.

iii. Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.

iv. An Elder-centred community creates opportunity to give as well as receive care. This is the antidote to helplessness.

v. An Elder-centred community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.

vi. Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.

vii. Medical treatment should be the servant of genuine human caring, never its master.

viii. An Elder-centred community honours its Elders by de-emphasizing top down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.

ix. Creating an Elder-centred community is a never-ending process. Human growth must never be separated from human life.

x. Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute."

The Fern Haven House (dementia unit) has gained recognition for embedding principle 1 to 6 and 10 and the rest home/hospital sections have commenced their Eden journey and gained recognition for principle 10.

There are nine documented 'ongoing objectives' and relationships with the community (individuals and groups) hat will be maintained and developed to ensure positive relationships, communication and support between all invested parties. The statement of purpose includes maintain a home like relaxed caring environment. In addition there is documented components on meeting resident's social needs, meeting resident's physical care and dietary needs in a holistic manner, security, maintaining the environment

There is a strategic plan and operational goals (2014-2015). The goals relate to facility maintenance, capital equipment purchases, review of some components of corporate services, some financial goals, and several goals related to governance functions.

The staffing policy identifies that the chief executive officer (CEO) and clinical manager/ facility manager will be available during office hours and on call 24 hours a day. Both managers hold a current qualification or have experience relevant to both management and the health and personal care of older people, and are able to show evidence of maintaining at least 8 hours annually of professional development activities related to our sector. The policy notes the role of the managers includes ensuring the welfare of residents and their every day care needs are met.

Onsite audit: It is verified at the onsite audit that the CEO, clinical nurse manager and the newly appointed general manager are suitably qualified and experienced, with authority, accountability, and responsibility for the provision of services. The sighted job descriptions for the management team, identify the clearly defined roles and responsibilities. There is a recent restructure of the management team and transition plan for the restructure of the current CEO role. This includes replacing the CEO with a general manager (has been in the role for two weeks), a human resources manager and increasing the hours for the clinical management roles.

In addition to the management team, there is an executive subcommittee of the Board and a full Board. The facility management report to, and work closely with, the executive committee. The executive committee meet a least monthly, with a full board meeting occurring bi-monthly. Interviews with one of the board members and member of the executive committee reports that the service is focused on the implementation of the Eden philosophy. The board reports confidence in the management of the services. The board member interviewed reports that the community support and involvement of the community, along with the 'Edenising' of the service are strengths of the service.

The staff and nurse practitioner report the service is managed very well.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

During a temporary absence of the CEO/general manager the clinical nurse manager performs this role. The clinical nurse manager is a suitably qualified and experienced person. The clinical nurse manager is a registered nurse (current APC sighted) and has worked at the service for two years. The clinical nurse manager attends ongoing education in aged care and the Eden Alternative philosophy. The CEO reports confidence in the clinical leaders' ability to perform the managers' role during temporary absences. The CEO reports they feel confident to perform the role of manager during temporary absence.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The quality plan notes there are ten different policy manuals. These are to be reviewed as per the review schedule. With the exception of the village policy and procedures the policies are reviewed externally and updated internally.

The quality plan includes identified activities/goals and who is responsible for achieving these, by when. The goals include (but are not limited to) training, review of the RN roster, review of diversional therapy staffing, introduce the role of clinical coordinator, undertake a full review of the emergency and pandemic plan, completion of the internal audit programme and training residents and staff on the Eden philosophy. The quality plan is reviewed with green colour coding being used to identify if the objective has been achieved and red where the activity remains in progress. The plan includes monitoring health and safety, infection prevention and control, restraint minimisation training, undertaking fire evacuation drills, and ensuring client care is evaluated and planned as required by the Aged Related Resident Care contract with the DHB. Refer to 1.2.3.1 for the continuous improvement rating.

There is a document control system to manage the policies and procedures. The polices are updated at least two yearly, or earlier if there are legislative changes. The policies and procedures are developed by an aged care consultant and are individualised to the organisation. New and updated policies are displayed in a folder and staff sign that they have read the updated policies. The staff only have access to current policies and procedures, with obsolete documents removed from staff access.

There is a risk management policy and associated risk register. This details a commitment to manage risks in line with national standards. The risk register includes (but is not limited to) a range of risks including risks related to the facility, care, natural disasters, resident/visitors/staff related, plant and equipment related, contractual, staffing, training, employment related risks, legal risks, information and communication risks and strategic risks. The likelihood of the risk occurring is identified along with who is responsible for reviewing each risk. The controls are noted and how the risks will be reviewed/audited. The risk register uses colour coding to identify the level of risk.

There are a number of hazard registers. These have been developed per department. Hazard registers are sighted for the HCAs/RNs, laundry, kitchen, office, hair dressing studio, physiotherapy service, workshop and a register related to driving hazards. There is also a generic organisation hazard register. These registers identify potential hazards, whether they can be eliminated, isolated or minimised, the hazard controls and the frequency of review. Whether training is required is also noted. The hazard registers sighted are dated as being reviewed in April 2014.

The quality and risk programme details the corrective action process. There is monitoring, assessment, action, evaluation, and feedback. All data is trended and trends are analysed by the quality committee and corrective action plans are developed as required. Results of trends and required corrective actions are discussed at the monthly staff meetings as confirmed by staff and management interviews and in minutes sighted. Data is benchmarked by an external contracted service and all results are shared with all

staff. Interviews with seven HCAs and three RNs confirm they are aware of quality systems and that they are informed of audit results at staff /quality meetings. Staff confirm that open discussion occurs related to all quality and risk issues and that meetings are used to measure quality improvement outcomes (sighted in meeting minutes).

Documentation identifies that corrective actions are put in place as required and evaluated to see if they have improved the service. Corrective actions are put into place to address identified areas for improvement as appropriate. Corrective action plans sighted cover all aspects of service delivery and they are discussed at all levels of the organisation. Corrective actions are developed as a result of identified trends from monthly data collation, internal and external audit results, deficits identified by staff during meetings, as a direct result of consumer survey results and from complaints received. Corrective action plans sighted have measurable outcomes and they are evaluated in a timely manner.

Monthly quality/staff meetings have trended data and benchmarking results presented as part of the standing agenda. The staff/quality meetings are used to review corrective actions put in place. This is confirmed by minutes sighted which identify that meeting topics include matters arising, equipment, care planning, governance meeting outcomes, maintenance, complaints, staffing, wound care, resident transfers, restraint, education, environmental issues, health and safety, complaints, accident and incident reporting, infection control, and quality improvements.

The DHB contract requirements are met.

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: CI

Evidence:

The achievement of Rangiura home's quality and risk management system, which is understood and implemented by staff, is rated beyond the full attainment level. The service has conducted a number of quality improvement projects which involve a review process which includes analysis and reporting of findings. There is evidence of actions taken based on findings and improvement to service provision. The sampling of projects includes the Eden Alternative approach, the role of Eden Ambassadors, the Fern Haven environment for residents with cognitive impairment, falls reduction programme. The service has gained recognition, both nationally and internationally for the Fern Haven Houses that was designed and built with the Eden Alternatives' 'Greenhouse Memory Support Home'.

The evaluation of these projects evidences positive results in residents' safety and satisfaction. Family interviews at the time of audit report that the care provided at Fern Haven is of such a high standard of that 'cannot be compared' to the dementia unit that their relative was at previously and the difference is 'like night and day'. Family members have reported that they saw an immediate improvement in their relative's behaviours, abilities and happiness. With one family member reporting that they relative used to 'cry all the time' and is 'dancing every day'. The outcomes of the quality project results are fed back to the Board, staff, residents and family/whanau. The organisation quality and risk management systems are understood and implemented by the staff (confirmed at interview with the 19 staff from across all sectors of service delivery).

Finding:

There is evidence from the review of a number of quality improvement projects that the quality and risk systems are continually reviewed, evaluated and improved. The service has gained recognition for becoming the first Australasian centre for the implementation of the Eden Alternative in the built environment of the Fern Haven House dementia facility. The organisation can demonstrate a number of innovative programmes that have impacted positively on the safety and satisfaction of residents. Staff at all levels of the organisation are involved in the implementation of the quality improvement projects.

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The accident incident and near miss reporting and investigating policy details the events that staff are to report and the reporting processes. Policy details the events that are to be reported as essential notifications.

An alert system is in place that identifies all adverse, unplanned or untoward events and provides an opportunity for improvement to manage risk. The staff and management interviewed understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The clinical nurse manager reports that there have been no serious incidents or accidents that have required essential notification. Interviews with the staff confirm their understanding of the need to document all adverse events.

The service uses accident and incident forms to document adverse, unplanned or untoward events. This information is monitored, evaluated and benchmarked. The monthly reports of the incidents and accidents records the number of incidents and accidents. The data is benchmarked with another care aged care facility. The data includes the total number of falls, times of falls, if any trends have been identified and the identification of frequent fallers. Shortfalls identify opportunities to improve service delivery and manage risk, this includes implementing strategies at the increased times of falls, or specific interventions for frequent fallers. Results of incident and accident trend analysis are discussed at the monthly staff/quality meetings and reports are presented to the owners as appropriate (for example, if there is serious injury).

The nine of nine residents, four of four family/whanau member interviews, and documentation sighted on incident/accident forms in nine residents' files, confirms family/whanau are kept well informed of their relatives care requirements and are contacted appropriately by the service if there are any concerns.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The hiring of staff/staffing overview policy (June 2014) notes a comprehensive process will be undertaken where by prospective staff will be asked to submit a CV, participate in a formal interview and if shortlisted, Rangiura will ensure that full reference checking is undertaken. Whenever possible Rangiura endeavours to ask our residents to be part of the interview procedure thus allowing resident input and participation in the process.

Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The CEO/clinical nurse manager ensures that staff who require practising certificates have them validated annually. Practising certificates are sighted for all staff and contracted staff who require them .

Human resources practices are implemented as per policy requirements and 11 of 11 staff records reviewed identify that staff are employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate. Staff appraisals are up-to-date and used as a method for staff to identify educational needs. The sighted annual performance appraisal or three month post-employment reviews are based on the staff members role and job description.

The service undertakes regular in-service staff education which is well documented and identifies that guest speakers/educators along with current RNs present education (content of education sighted). Refer to 1.2.7.5 for the continuous improvement rating.

All staff working in the dementia unit have completed the required dementia specific unit standards. The service supports the care staff to complete their national qualification in the support of the older person.

The nine of nine residents and four of four family/whanau interviews and the November 2013 resident/family survey results sighted confirms services are delivered in a manner to meet required needs. The residents and families report that the quality of the care and caring nature of the staff is one of the strengths of the service.

The DHB contract requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)
Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)
New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: CI

Evidence:

Rangiura has an embedded system to identify, plan, facilitate and record ongoing education. The service has reviewed and analysed the staff development and ongoing education programme. The analysis records that over 2013 and to date in 2014 the service continue to invest in staff through ongoing training and development. The statistical review (2013/2014 financial year) shows that the service financed approximately 20hrs training per staff member. The ongoing education covered over 60 topics offered across online training, ACE programme, in-service education, external courses and self-directed learning packages. All the Fern Haven staff have completed or enrolled in the ACE dementia programme. In 2013, 51 had completed or are working through the ACE modules, with a total of 40 staff completing their national certificate qualification. Ongoing education is provide in the Eden Alternative. The service has 18 fully qualified Eden Associates and one Eden Trainer.

The physiotherapist runs regular formal and informal education on manual handling, restraint minimisation, as well as one to one mentoring and support related to any identified areas for improvement.

The nine of nine residents and four of four family/whanau interviewed report high satisfaction with the level of knowledge and skill of the staff. The satisfaction is also measured through resident, family and Eden satisfaction surveys. Resident safety is reviewed and analysed through the incident and accident reporting system. Residents also commented that they are also able to attend the ongoing education sessions if they desire. Residents and families also provided statements such as “they cannot possibly see how the quality of the staff or service delivery could be improved on”.

Finding:

The system to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to residents is rated beyond the full attainment. The ongoing education that is provided exceeds the requirements set out by the district health board. An analysis of the education and professional development occurs through the operational reports. These reports show the range and investment in staff education and ongoing training that has been implemented. The implementation of the ongoing education programme is providing positive outcomes in resident safety (for example reduction of injuries) and high resident and family satisfaction in the quality of the care provided.

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:

As part of the ongoing reporting processes we review and analyse staffing numbers and mix on a regular basis in reference to service levels and guidelines in the MOH SNZ HB 8163: 2005- Indicators for Safe Aged Care. Data is collected and recorded against these standards and reported on to the Trust Board and staff on a regular basis. Junior staff are to be supervised by senior staff. The staffing policy sighted meets the DHB requirement for rest home/hospital and dementia services. The layout of the facility is also taken into consideration when determining the number and the distribution of care staff required to meet the needs of the resident. A nurse practitioner visits twice a week.

A full time physiotherapist and clinical coordinator are on duty Monday to Fridays. The RNs work across the rest home/hospital and dementia service. In addition to the management team and clinical coordinator, there are two to three RNs on morning shift, one to three on afternoon shift (when there is one RN there is also an EN on duty) and one RN on night duty.

The rosters sighted for the care staff confirm the following:

-Rest home/hospital (rest home and hospital wings with a maximum of 52 residents): nine HCAs on morning, seven to eight HCAs on the afternoon shift and three HCAs on nigh shift (this includes one HCA who works as a 'floater' between the rest home/hospital and the Fern Haven House dementia unit). There is an additional shift coordinator that works four days a week.

- Fern Haven secure dementia unit (though a maximum 20 beds the service currently uses 17 beds): three HCAs on morning and afternoon shifts and one HCA on night shift (plus the floater that covers the rest home/hospital and Fern Haven dementia unit). In addition to the HCAs, there is an EN and diversional therapist on duty Monday to Friday.

There are adequate numbers of support staff, that include administration, cook, kitchen assistants, cleaning staff, laundry staff and activities coordinators, ACE assessors, rehabilitation assistant and Eden ambassadors. Interviews with seven HCAs (from rest home/hospital and Fern Haven secure unit and staff who have worked morning, afternoon and night shifts) confirms that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. This is supported by interviews undertaken with nine of nine residents and four of four family/whanau members.

The DHB requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The collection, use, storage and security of information policy details how personal information will be collected, stored and used in a secure and appropriate manner and in accordance with the Privacy Act and the Health information Privacy Code. Resident records are to be kept for ten years after the resident last received services. The service retains relevant and appropriate information to identify residents and to track records. A register is maintained of current residents. A data base and system is in place for past residents and an archive room is available for storing the records. Records can be easily retrieved when and if required.

Staff can describe the procedures for maintaining resident`s records in a comprehensive and confidential manner. Each file contains resident information, clinical records, clinic appointments and consultations with other health professionals and discharge summaries if admitted to the DHB or out patients` clinics for assessments. All records are integrated. There is sufficient detail in residents` files to identify residents` ongoing care, history and activities plans. Progress notes are written each shift. Care progress notes include designation, and the writer can be easily identified. There is an allied health professionals section which includes the physiotherapist, medical, laboratory service results and investigation performed (PATHLAB), health and safety and any correspondence. A communications record with family/whanau/representative is well utilised. Unique identifiers are on each page. Label are used.

Internal audits are conducted to ensure that resident records are maintained in a manner which complies with both internal and external standards.

There are policies and procedures in place for privacy and confidentiality. Resident files are stored securely in the rest home hospital nurses station and in the dementia service. Computers are password protected and include levels of access.

The DHB requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

The services operates seven days a week twenty four hours a day. There is always senior staff available should residents/family/whanau wish to look over the facilities provided. This service provides rest home, hospital and secure dementia care services for this community. The service has a Trust Board of community representatives which manages the organisational management. There is a CEO and a clinical nurse manager who oversee the day to day running of the home. An information pack is available for both the rest home hospital and for Fern Haven House the secure dementia unit. The Eldernet web site provides information about the rest home and hospital and the dementia service. The service has additional contracts with the WDHB to provide palliative care and day care.

The resident admission policy is available in the service manual and there is clear documentation regarding the criteria for entry. The resident agreements are visible in the nine of nine resident files reviewed. The admission agreement is based on the New Zealand aged Care Association agreement which covers all contractual requirements. In addition the agreement contains information about when the resident is required to leave the facility.

All residents are pre-assessed either in the community, at another facility if an InterNASC transfer is to be arranged or by the geriatrician at the WDHB prior to admission. All Needs Assessment Service co-ordinators are responsible for completing a comprehensive InterRAI assessment to establish the level of care required prior to the admission and/or respective service. These agreements are all accessible and retained in the individual resident files reviewed.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The service uses the entry/admission form/book to record enquiries to this service. A waiting list folder is available for pending admissions. This is maintained by the clinical nurse manager. The occupancy and services are explained when resident/family/whanau visit the facility. Tours are provided by the clinical nurse manager or the registered nurses. Information packs are made up ready for giving to prospective residents/family.

Seldom are residents declined due to the services provided. If a potential resident has not completed the appropriate assessment for rest home, hospital and/or specialised dementia care services, the admission details are communicated with the referrer. If alternative services are required full assistance is given by management and the NASC service is contacted.

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:

The service has extensive care and management policies which are located in the service manual and are accessible for all staff to read and to provide guidance as required. The policies and procedures are all current and have been reviewed as per the audit schedule reviewed.

The physiotherapy policy notes within 48hrs of admission, a brief assessment of the residents` ability and manual handling requirements should be performed by the physiotherapist. A manual handling care-plan is devised, and where appropriate, located in the inside door of the wardrobe in the resident's room. These plans are available and visible in every resident`s individual room. A full detailed assessment, recording the resident's physical and cognitive state, are completed within two weeks of admission as discussed with the physiotherapist.

The medical services policy details the frequency residents will be seen by their GP/nurse practitioner and the associated documentation required. This includes to be seen within 48 hours of admission and thereafter a minimum of monthly reviews or three monthly if documented as being clinically stable. Stamps are utilised in the clinical records in the nine of nine resident files reviewed and a letter is evident in each file if three monthly reviews are to occur. Three monthly medicines review is required and completed by the GP and/or the nurse practitioner.

Each stage of service delivery inclusive of assessment, planning, provision of care, review/evaluation is undertaken by suitably qualified staff who are competent to perform their role. The nine on nine resident files reviewed (three rest home, three hospital and three dementia care) confirm that the registered nurse (RN) conducts the comprehensive initial assessment and develops the short term initial care plan on admission to this service. The momentum long term care plan is developed within three weeks of admission with the resident and family/whanau input. There are nine registered nurses and two enrolled nurses each of whom have a valid annual practising certificate. The clinical nurse manager is responsible for ensuring a system is in place for checking and validation of the APCs annually.

Additional recognised assessments are currently utilised as well as InterRAI which is an international resident assessment instrument, a standardised assessment tool, that uses software designed to improve the care of older people in residential care facilities. (A comprehensive clinical assessment which includes a range of health assessment tools). The momentum InterRAI care plans identifies the needs, desired outcomes or goals, level of support required and the interventions and support required. The multi-disciplinary review is conducted initially three monthly then annually and input is sought from the activities co-ordinators/diversional therapists, the GP and/or nurse practitioner, pharmacy, dietitian if required care staff and the physiotherapist applicable to the resident (also involves the resident and family/whanau) to review the resident`s individual needs. The momentum InterRAI care plans are reviewed six monthly and more frequently if there is a change in the resident`s status. The evaluations ensure the desired outcomes or goals are met and progress towards achievement of outcomes occurs. This is evidenced in the nine of nine resident files reviewed.

The nine resident and four family (two dementia unit & two hospital) report high satisfaction with the service and report that the community is fortunate to have such a service in their community. Staff work as a team and continuity is encouraged. The GP was not available for interview however the nurse practitioner who visits the facility four days a week discussed at interview the high quality of care and services provided at this service.

There are one area of identified continuous improvement in relation to the comprehensive momentum InterRAI care plans which have been developed and implemented for all services.

The DHB contract requirements are met.

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 Dementia Care:

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: CI

Evidence:

The nine of nine InterRAI momentum care plans reviewed are documented to a high standard, initially taking into consideration the InterRAI NASC Disability Support Link assessment prior to admission and subsequently the comprehensive assessment performed by the senior registered nurses on admission to the services. Presently additional recognised assessment tools are also utilised and re-evaluations occur on a regular basis to ensure the interventions are appropriate and that the goals set for each resident can be effectively met. All staff contribute into the care planning and review processes.

Finding:

A continuous improvement rating is made for the high standard of documentation into the individual momentum care plans and input acknowledged from staff involved in the personalised care and management of the individual residents at this rest home, hospital and dementia services. Interventions are discussed as to what is best for each individual resident not what is expected in relation to meeting goals set by the individual residents themselves.

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The nine of nine residents` files reviewed have appropriate assessments to meet the needs of the resident. This organisation has ensured all nine registered nurses employed have been fully trained to undertake and to utilise the InterRAI long term care facilities assessment tool (LTCF). InterRAI is a comprehensive clinical assessment being introduced into aged residential care. It is designed to help registered nurses understand the needs of their residents in order to plan care. The data collected can be compared locally, nationally and internationally.

The nine of nine resident files reviewed evidence interRAI assessments have been performed prior to admission by the NASC service Disability Support Link co-ordinators and then each resident on admission is assessed using the InterRAI assessment tool. From this comprehensive assessment an initial short term care plan is developed and implemented and within three weeks the InterRAI Momentum care plan is developed by the registered nurse. All care plans have been developed and implemented at this facility for all residents.

Ongoing assessments using the InterRAI LTCF as the primary assessment is now utilised on an ongoing basis. A schedule is being developed to evidence when the respective assessments are to take place. The advantages of using InterRAI are becoming apparent and direct accessibility and information is more streamline for a new resident and at the six monthly reassessments. The tool standardises the assessment process and is reducing the need for separate risk assessments. Evidence of a resident being transferred to the DHB (the assessment information followed the resident) as well as a transfer form being completed and placed in the yellow envelope. Information about the resident`s needs is clear and easy to access. The staff interviewed are finding this assessment more efficient and accessible the more it is utilised.

The four families and nine of nine resident interviews report satisfaction with the care received and residents felt their individual needs are being met.

An area of continuous improvement has been identified in relation to the comprehensive assessment process performed and utilised for all residents in all services provided.

The DHB contract requirements are met.

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: CI

Evidence:

Nine of nine resident files reviewed evidence the comprehensive assessment process serves as the basis for service delivery planning. Goals and objectives are developed from ascertaining the individual needs from the assessment process. The mandatory Ministry of Health assessment tool to be introduced in 2015 is readily embraced and is being embedded in this organisation in conjunction with the Eden Alternative philosophy. All nine of nine registered nurses have been fully trained to implement this system into this residential care facility inclusive of Fern Haven House the specialised dementia care service available on site.

Finding:

Having fully attained the criterion the service can in addition clearly demonstrate the high standard of documentation into the InterRAI assessment process. The process is comprehensive and along with the pre-admission assessment and the physiotherapy functional assessment (inclusive of falls risk and manual handling assessments) is readily available and accessible when developing the Momentum InterRAI care plans and is improving the service delivery for all residents in all services.

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:

The nine of nine care plans reviewed have a standardised format that is individualised to the resident`s assessed needs. The records of the three tracer methodologies identifies clearly the needs and care requirements of each resident. Specific plans to respond to reduce falls for one resident is obvious and well documented. The nine of nine records reviewed demonstrate integration inclusive of input from care staff, activities co-ordinators/diversional therapist, medical and allied health services. The seven of seven health care assistants interviewed report they receive adequate information to assist the continuity of care. The handover includes updates of residents, additional monitoring required, specimens sent to the laboratory and results provided.

The nurse practitioner interviewed, four family members and seven of nine residents report a high level of satisfaction with the quality of care provided at this service.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA

Evidence:

The service has adequate dressing and continence supplies to meet the needs of the residents. The nine of nine care plans reviewed record interventions that are consistent with the residents` assessed needs and desired outcomes/goals. Observations on the day of the audit indicate residents are receiving care that is consistent with the residents` needs. The four family members interviewed and seven of nine residents report that the service meets the needs of the residents. (Two residents in the Fern Haven House could not comment about the service meeting their needs). The interventions put in place to meet residents` needs are monitored by the registered nurses. Interventions are changed as required and the care plans are updated.

The DHB contract requirements are met.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)
The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is one fully qualified diversional therapist and two activity co-ordinators in training who oversee the activities programmes for the rest home, hospital level residents and for the dementia service. The activities co-ordinator interviews (three staff interviewed separately) evidence the activities are modified for the different abilities, interests, likes and dislikes of residents. The diversional therapy profiles are completed within two weeks of a resident being admitted to this service. Likes, dislikes, interests, culture, religious affiliations previous employment, family & social histories are taken into consideration.

Each resident has a diversional therapy care plan which addresses physical activities, intellectual activities, social and community involvement, sexual/intimacy, emotional needs and spiritual needs. Also a `This is me` is developed with the resident and/or family member and displayed in each resident`s room. The involvement of the resident/ family/whanau is recorded dated and signed when developed fully. Diversional therapy goals are documented on the reverse of the assessment record and two goals are documented for each individual resident and the intervention or planned outcome to achieve goals set. Each are signed off and the next review date is documented for follow-up. Each month the `Rangiura Rag` is documented in the form of a brochure highlighting up and coming events, activities and meetings to be held. The birthdays for the month are displayed on the two main notice boards in the rest home hospital, Fern Haven House, dayroom and individual residents receive a copy. A copy is also displayed on the wall in the kitchen.

The weekly activities are documented and colour coded with red for hospital/continuing care, blue for rest home/day care and black is combined activities. Social interaction and activities are held 9am – 4pm daily. Activities are planned to meet the needs of the residents. The service has a bus outing a couple of times weekly and community events are encouraged. People from the community participate and provide many of the activities. One on one activities are encouraged as well with the hospital level residents as required.

There is a residents meeting which is held three monthly and residents representatives are displayed on the notice board along with photographs of each individual on the committee. The meetings are facilitated by volunteers and management. The minutes sighted evidence residents are happy with the activities provided.

Fern Haven House: All residents are encouraged to participate but are free to decline. Individual assessed specific activities are documented in residents care plans and on the monthly calendar. The Fern Haven House weekly activities plan covers 24/7 6am – 6am daily seven days a week. The Fern Haven House calendar of events is displayed with the days and times of events planned. Outings are arranged separate from the rest home and hospital. Records are maintained. The community quilters have made quilts which are visible on all the beds in Fern Haven House. The Eden alternative is intertwined with the activities programme effectively. The activities care plans are reviewed at the same time that the care plans are reviewed for all residents whether rest home, hospital and/or dementia level care.

The DHB contract requirements are met.

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:

Nursing reviews and assessments, medical (GP and/or nurse practitioner) and specialist consultations and admissions to hospital for specialist treatment is clearly documented in nine of nine residents` files reviewed. Documentation reflects that evaluations of care plans are conducted at least six monthly. Evaluations are documented, resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes/objectives/goals set. If a resident is not responding to the services interventions being delivered, or their health status changes, then this is discussed with the GP and/or the nurse practitioner interviewed. Residents` changing needs are clearly described in nine of nine care plans reviewed. Short term care plans are sighted for wound care, pain management, changes in mobility, changes in food and fluid intake and skin and soft tissue injuries/care. These processes are clearly documented on the short term care plans, medical and nursing assessments and the residents` progress notes reviewed.

The multidisciplinary review meetings occur three monthly after admission to any of the services and then six monthly. The four family members at interview report their input is sought into the six monthly MDT meetings.

The DHB contract requirements are met.

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 registered nurse on duty or the GP/nurse practitioner arrange for any referral to specialist medical services when it is necessary. The nurse practitioner and the registered nurses interviewed confirm that referral services respond promptly to referrals made. Records of the process are maintained as confirmed in nine of nine residents` files reviewed, which included referrals and consultations with urology, orthopaedics, radiology, cardiology and dietitian services. The nurse practitioner interviewed reports that appropriate referrals using the InterRAI system is well managed by the registered nurses at this service.

The DHB contract requirements are met.

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:

If a resident`s condition or health status changes the GP/nurse practitioner is notified. Should a resident require higher level of care such as higher dementia level of care, a referral is sent through the InterRAI NASC service for a reassessment to be performed. When approved, assistance is provided to families in the event of this occurring. Rest

home to hospital level care is provided on site and transfer to the dementia service can be arranged if and when required. If a resident requires a referral and transfer to the DHB Waikato or Tokoroa depending on the needs identified this is arranged by the staff.

In an emergency situation the resident is transferred immediately and the GP or nurse practitioner is informed. Transportation by ambulance if needed is arranged. The resident register is up dated and a record is noted in the resident`s individual record of the admission or transfer. A specific transfer form is completed and any known risks, allergies/sensitivities are recorded. The yellow bag system has recently been implemented for transfer to a DHB. The information record, medication record, advanced directive, resuscitation status and a last DHB discharge summary if available is photocopied and placed in the yellow envelope provided. Family/whanau are notified and a record is clearly documented on the communication family/whanau form in the front of the individual resident`s file.

The DHB contract requirements are met.

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:

Policies and procedures are present for all aspects of medication management practices as required to meet this standard. The policies are dated October 2013 and reflect safe and timely medicine management. Policies comply with current legislative requirements. The pharmacy does have input and audits are performed six monthly as per the audit schedule. The pharmacist checks all medication packs when leaving the pharmacy and the registered nurses check them on arrival to the facility. The pharmacy dates and signs each pack sighted prior to sending to this facility. The policies include the process for residents to self-administer medications. They must first be assessed as competent by an RN and approved by the GP or NP. Only one resident self-medicates medication (inhalers) and the file was reviewed.

Staff who administer medicines must be competent to do so. An extensive process occurs should senior experienced care staff or enrolled nurses administer medicines. Three questionnaires have to be completed and a practical audit is performed with a full sign off by a registered nurse or the clinical nurse manager. Full supervision is given

by the registered nurses. Suitability for non-registered staff is the responsibility of the clinical nurse manager. The clinical nurse manager maintains all records required. Staff are observed giving out lunchtime medications in a safe and appropriate manner. There are two medication trollies for the rest home/hospital and one for the dementia unit. When not in use they are locked and stored in the medication rooms in both areas sighted.

All medication is stored and the temperature of the medicines fridge is monitored daily. Controlled medications are checked by two registered nurses or a registered nurse and one enrolled nurse every Friday night and a weekly stock take is recorded in the controlled drug register. Legislative requirement are met and guidelines reviewed are available to guide staff.

Eighteen medication records reviewed evidenced three monthly reviews are completed by the GP and/or the nurse practitioner and this is recorded on the medication records reviewed. The blister packs are safely managed and are working well for this service.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The food safety policy (July 2014) provides guidance for staff on food safety principals related to defrosting, storage/segregation, food tasting, food reheating, hand hygiene and care of chopping boards.

The policy notes residents will be assessed on admission and food preference and dislikes, religious and ethnic restrictions, medical and dietary modifications and eating and drinking limitations identified and communicated. A six week rotating summer/winter menu has been approved after a full review by the contracted dietitian service (NZ Registered Dietitian) on the 13 August 2014. The menu review is based on the dietitian NZ audit for nutrition and dietary variety, Ministry of Health Guidelines for older adults and Australian standardised definitions for texture modified food and fluids.

Advice is also sought by the clinical team via the clinical nurse manager for some up to date information with regard to diabetic diets, and guidance on fortified drinks and meal replacements and this was provided and recipes given as well that would be easily made up by kitchen staff as needed for individual residents to meet their needs.

On admission the registered nurse completes the dietary profile for each resident and a copy is provided to the cook and a copy is retained in the resident`s files. The needs, wants, dislikes and special diets are then catered for by the cook. The service provides special diets as required such as diabetic, gluten free, low fat and increased caloric diets to meet specific residents` needs. Interviews with nine of nine residents, and four family members confirm they are overall happy with the food provided. The residents can choose their own evening meal from the menu provided each day at lunchtime.

The main cook is interviewed and discussed all aspects of food procurement, production, preparation, storage, delivery and disposal which complies with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet the requirements. Normal temperatures are displayed in the kitchen on a wall chart. All staff who work in the kitchen have completed food safety management education appropriate to service delivery. The kitchen service audits are undertaken and an internal audit occurred August 2014. There is a cleaning schedule which is acted on daily and high additional cleaning is carried out by the maintenance personal for this service.

The main meals to the dementia unit are transported in a heated trolley at lunchtime and dinner time. Temperatures of food are taken when leaving the main kitchen and on arrival in the unit. Breakfast can be prepared in the kitchen in the unit daily by staff. Family assist with the nutritional profiles on admission to ascertain what individual residents like and dislike.

The DHB contract requirements are met.

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:

Policies detail the process for managing chemical spills. The chemical safety data sheet is to be available and referred to ensuring correct procedure is followed. Chemicals are to be in correctly labelled bottles. The laundry policy notes staff are able to access cleaning equipment and laundry chemicals from a locked store room which ensures safe and hygienic storage. All chemicals are broken down into manageable and economical volumes, labelled accordingly, and stored under the sinks.

The policy notes appropriate HAZCHEM warning signs should be placed on the external walls of all buildings that house hazardous substances. A register of all Material Safety Data Sheets (MSDS's) is available to all staff. If there is any doubt about whether a material is hazardous or not, treat it as hazardous until informed otherwise.

The following protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled: goggles and masks, gloves, adequate ventilation in storage and use areas, aprons, and shoe covers. There is a medical waste policy which details the process for disposing of controlled waste, sharps, and non-hazardous waste.

The two cleaners and two laundry staff interviewed report that they follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation. There is appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The laundry worker/cleaner interviewed reports that they have had training in the handling of waste or hazardous substances, which is conducted by the external chemical provider and as part of the ongoing in-service education programme.

The DHB contract requirements are met.

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:

Building Warrant of Fitness expires 7 December 2014.

Equipment is maintained to ensure safety. Electrical tag and testing was last conducted in August 2014 The calibration of the medical equipment is last conducted in April 2014 (includes hoist, nebuliser, electric beds, sphygmomanometers, thermometer and regulator). The service has a planned and reactionary maintenance programme, with the building maintained in an adequate condition appropriate to the age of the building. The maintenance log notes the area of work required and is signed off when the work is completed.

The fittings and furniture installed are maintained to ensure safety and the needs of the rest home, hospital and dementia level of care residents. The physical environment is appropriate for the residents. Hand rails are installed in corridors as appropriate in the higher level of care wings. There is disability access at all entrances that are not at ground level. There is an ongoing maintenance and refurbishment plan for the service. It is noted that some surfaces of items such as pad pans, urinal and some of the equipment have surfaces that are beginning to deteriorate. This is identified and is part of the ongoing maintenance schedule to be replaced. The residents' rooms sighted are personalised with the resident's possessions. Residents are provided with safe and accessible external areas that meet their needs.

Hot water temperatures in resident areas are monitored monthly by the maintenance worker. The temperatures sighted are within the safe temperature guidelines for aged care.

The Fern Haven House (secure dementia unit) is designed to promote a safe area in which the residents can wander freely.

The DHB contract requirements are met.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)
All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are adequate numbers of accessible toilets/showers/bathing facilities, conveniently located and in close proximity to each service area to meet the needs of the residents. The service has a mix of rooms with single or shared ensuites and communal facilities. The shared/communal facilities are located in each wing of the rest home/hospital sections. The toilets and showers in the common areas are clearly identified and have engaged/vacant privacy signage. The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines.

The facilities in Fern Haven House are separated from the rest of the service. All rooms in Fern Haven have ensuite facilities.

The nine of nine residents and four of four family/whanau report satisfaction with the toilets and shower facilities.

The DHB contract requirements are met.

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:

All rooms are single occupancy. The rooms sighted are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents can freely move around the facility. The nine of nine residents and four of four family/whanau report satisfaction with their rooms.

The DHB contract requirements are met.

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: CI

Evidence:

There are lounge and dining areas throughout the facility in both the rest home/hospital and Fern Haven House. There are lounge areas, dinning and recreational areas in the rest home/hospital sections and a separate sitting areas in each wing. The rest home/hospital sections have a separate chapel or family/whanau room for smaller groups. The lounge and dining areas are separated and activities in these areas do not impact on each other. There is a designated space in the hall in the rest home/hospital sections for larger group and community activities and events.

The Fern Haven House facilities are separated from the rest home/ hospital section, with lounge, dinning and kitchen areas that are suited to the residents with cognitive impairment. The design of Fern Haven House is based on the Eden Alternative principles. Fern Haven House is a purpose built 'Greenhouse Memory Support Home' and is an Eden register home. Refer to 1.4.5.1. for the continuous improvement rating.

The nine of nine residents and four of four family/whanau interviewed report satisfaction with the lounge and dining facilities.

The DHB contract requirements are met.

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: CI

Evidence:

The built environment at Fern Haven House is rated beyond the fully attainment in providing appropriate lounge, playroom, visitors and dining facilities that meets the needs of residents with cognitive impairment/memory loss. Fern Haven House is a registered Eden home. The purpose built environment is based on the Eden "Greenhouse Memory Support Home'. The environment, design and mission of Fern Haven is to provide a home environment where residents can continue to live with dignity and respect. It is evidenced through ongoing Eden audits and satisfaction surveys that the resident satisfaction is improved through providing ongoing holistic car appropriate to individual resident's needs and desired outcomes. Fern Haven has national (through the an aged care association award) and international recognition (Eden Alternative seedling award) for embedding six of the 10 Eden Principles (2,3,4,5,6 and 10). Satisfaction surveys and feedback from relatives of residents living in Fern Haven report high satisfaction with the environment, which has had positive impacts on their relatives' quality of life.

Finding:

The achievement of providing residents with a safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs of residents with cognitive impairment is beyond the expected full attainment. Fern Haven House has gained national and international recognition as an environment to meet the needs of resident's living with dementia. Rangiura have conducted a review process which includes analysis and reporting of findings to staff, residents, relatives, national conferences and international conferences. There is evidence of action taken to implement the Eden 'Greenhouse Memory Support Home' which has resulted in improvement to service provision for residents and family/family in Fern Haven. The resident and family/whanau satisfaction has been measured through resident/family and Eden satisfaction surveys, which evidence improved outcomes for residents.

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:

Document review: policies and procedures (July 2014) details the process for cleaning and products to be used and frequency.

The laundry policy notes processes for storing, transporting and washing of linen. The methods, frequency and materials used in the laundering process are monitored for effectiveness through the internal audit process by the chemical supplier. Unwanted variations and trends are identified including those identified by resident feedback through our concerns complaints process.

Onsite audit: The cleaning and laundry services are conducted onsite by designated domestic staff. The laundry has a dirty to clean flow. The external chemical supplier conducts a monthly surveillance of the cleaning and laundry processes and sends this report to the services head office. The three domestic staff interviewed report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. It is noted that there was one bottle of chemicals on the cleaning trolley that was not labelled, this was replaced at the time of audit and is not reflective of a systemic issue. The nine of nine residents and four of four family/whanau interviewed report satisfaction with the cleaning and laundry services.

The DHB contract requirements are met.

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:

Document review: The security policy (June 2014) details the processes staff are to undertake to facilitate the security of residents. This includes ascertaining the identity of visitors and undertaking a lock down security check at night. There is a documented checklist which includes ensuring all doors and windows are secure and curtains and blinds closed.

The essential, emergency and security systems policy noted fire evacuations drills are to occur six monthly. The building warden is the senior RN on duty. The plan includes guidance for staff on managing security issues, challenging behaviour, and civil emergency. The staff manual for emergency procedures includes guidance for staff on managing:

- fire & emergency evacuation
- trial emergency evacuation
- earthquake
- storms
- gas leakage/ damage
- bomb threat
- civil defence
- accident and emergency resources
- evacuation procedures (other than fire)

- toxic fumes and hazardous substances

- building and staff security

- uncontrollable violent behaviour procedure

Another policy details the process for managing a chemical spill.

Onsite audit: Approved Fire Evacuation Scheme Status sighted is dated 3 November 2010.

The service has adequate emergency supplies in the event of an emergency or outbreak. The manager reports there is at least three days' supply of food and water for emergency use. There is a civil defence kit with emergency supplies, these supplies are checked six monthly, last conducted in July 2014. In the case of mains power failure the service has a generator and access to adequate drinking water in the event of emergency.

All resident rooms, bathrooms and lounge areas have a call bell system installed. There is a nurse call cord in each resident room, bathrooms, showers and ensuites. The call bell system has a light above the door and a central panel that indicates the room that has activated the call bell. There is a pager system in Fern Haven House, which alerts staff when a call ball/alarm mat is activated. There are additional emergency call points in the lounge areas through the facility. The nine of nine residents and four of four family/whanau report that the call bell is answered in a timely manner.

The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The seven HCAs interviewed demonstrate knowledge on responding to emergency situations. All senior staff have a current first aid qualification. There is at least one staff member on duty at all times that holds a current first aid qualification.

The service conducts six monthly evacuation training, with the last drill conducted May 2014.

The service identifies and implements appropriate security arrangements relevant to the residents at rest home/hospital level of care. The service has a secure dementia unit that is separated from the rest home/hospital section. The afternoon staff are required to close and lock the external windows and doors before it gets dark. The service has external security lighting. The HCAs interviewed, who have worked night shift, report that they feel safe and secure when working afternoon and night shifts. The nine of nine residents and four of four family/whanau interviewed report they feel safe and secure at night.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

Areas used by residents and staff are ventilated and heated appropriately. There is a mix of gas and electric heating through the service. All resident-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light and ventilation. The nine of nine residents and four of four family/whanau report satisfaction with the natural light, ventilation and heating.

The DHB contract requirements are met.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint minimisation policy notes Rangiura rest home, hospital and dementia service is committed to minimising the use of restraints and to providing staff with good guidelines to enable them to prevent the need for the use of restraints. Guidance for staff on managing challenging behaviour is included in the policy and processes to report and monitor episodes of challenging behaviour is noted. Staff training is to be given at least yearly on behaviour management and de-escalation techniques. Definitions of restraint noted including personal, physical and environmental restraint. Use of restraint is documented as being a last resort. The policy details various risks associated with use of different restraints and how these risks can be minimised. Restraints include bedrails, fallout chairs, lap belts, and safety harness in chairs.

Any recommendation for restraint is referred to the restraint coordinator. The restraint coordinator discusses this with the Doctor/Nurse Practitioner.

Alternatives to restraint discussed are documented in the individual resident`s care-plan. If the Doctor/Nurse Practitioner considers that restraint for safety is justified then he/she signs clearly in the resident's notes. There is evidence of appropriate communication with the resident and their family/whanau/caregivers of all decisions relating to restraint and this occurs in a timely manner. Any restraint prescribed is only instigated after consent has been obtained. It is only justified if an appropriate assessment is undertaken of the need to take the action each time the restraint is exercised and the decision to exercise restraint is reasonable in the circumstances. The individual resident's rights is maintained at all times and the chosen method for restraint is to be the least intrusive and restrictive and for the shortest time possible time.

There is a clear policy for enabler use which states they are used only for and as safety enablers to prevent residents from falling and at their own requests. Enablers are voluntary and aid independence and include bedrails, trays and other equipment). A consent form is required to be completed. The resident is to be monitored at least every two hours.

Currently the service has 10 residents assessed as requiring restraint use. The restraint/enabler assessment and evaluation form identifies that the enabler is the least restrictive option. One of the ten restraints in use is inclusive of one resident in Fern Haven House.

The restraint co-ordinator at interview explains the assessment process and restraint training held annually if based on the service policy which identifies that enablers are the least restrictive option. The four resident files assessed for the voluntary use of an enabler identifies that this is the least restrictive option. Observations and interviews with seven of seven health care assistants confirm enablers are voluntary, for safety and the least restrictive option.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The physiotherapist is the restraint co-ordinator for this service. The position description of the restraint co-ordinator identifies the roles and responsibilities for restraint authorisation (sighted) and confirmed at interview. The approval process includes gaining consent form the family, the GP and/or the nurse practitioner, a restraint authorisation consent form which is also signed by the restraint co-ordinator. The restraint is then recorded accurately in the restraint/enabler register which is well maintained by the restraint co-ordinator. The use of restraint is evaluated six monthly and annually at the multidisciplinary meetings for each individual resident using a form of restraint or an enabler. The care plan records the restraint or enabler use, as confirmed in the files sighted of residents with restraint or enabler use.

The DHB contract requirement is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint assessment authorisation includes points (a) to (h). The restraint assessment is comprehensive and does include the identified risk, assessment of the physical condition of the resident, potential effects on the resident, resident input into decision making, the type of restraint, frequency of monitoring and criteria for ending the restraint. The 10 of 10 residents using a form of restraint each have a care plan that records if the approved restraint is the least restrictive option, the type of restraint used, alternatives to restraint, risks associated with the chosen restraint, alternative to restraint use, consent and review periods.

The restraint committee includes the evaluation of the individual residents being restrained, if the restraint requires an evaluation to be completed, by who and the time frames. The register is reviewed to ensure it is up-to-date.

All requirements of (a) to (h) are acknowledged in the extensive assessment process reviewed.

There is an area of identified continuous improvement in relation to the comprehensive assessment process implemented.

The DHB contract requirements are met.

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: CI

Evidence:

The requirements for meeting the restraint minimisation and safe practice standard are effectively met. The restraint co-ordinator is very experienced and takes into account additional identified risks such as resident risk of falling and manual handling requirements for each individual resident ensuring all points (a) to (h) are totally considered during the assessment process. A comprehensive restraint/enabler assessment is implemented. A separate restraint risk questionnaire for residents/family to complete, a restraint evaluation form, a physical restraint consent form, a quality review of restraint use, a six monthly review audit, a daily restraint monitoring form and a documented information sheet for the resident/family. Also any risks are discussed as well as the assessment process requirements for restraint management. A checklist is available called` the manual handling and restraint minimisation orientation checklist and training record`. The restraint co-ordinator clearly links requirements of service delivery (managing falls risks), care planning objectives, managing challenging behaviour, health and safety (manual handling processes and education) and quality and risk systems.

Finding:

Having fully attained the criterion the service can in addition clearly demonstrate the high standard of restraint management documentation reviewed. The assessment process is fully undertaken by the restraint co-ordinator. A very experienced physiotherapist employed by this service for 14 years. The restraint co-ordinator interviewed fully comprehends the restraint minimisation standard and has developed and implemented with approval from management a complete restraint management package which is fully and clearly utilised for each individual resident who may require to use a form of restraint and/or an enabler. This has improved the restraint management for residents using restraint by ensuring all the needs of the residents are effectively met whilst a restraint is in place.

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:

Rangiura rest home hospital and dementia services ensures all staff are well trained and receive ongoing education on restraint use and competency. The restraint education is provided at commencement of employment during the orientation/induction process to this service and is provided at least six monthly. All staff who have resident contact are required to have a competency assessment. The education is included in the ACE programme which all staff complete and in-service education provided on a regular basis at staff meetings or at the staff `huddle` held mid-morning by the restraint co-ordinator and/or is needs assessed education which can occur based on individual needs identified in any incidents the restraint co-ordinator reports.

The restraint competency assessment includes the definition of restraint, the approved restraints used in this service, the monitoring process expectations, safety considerations at all times, and a section on the approval process and if the staff member is competent to apply and monitor the use of restraint. The staff competency checklist identifies that all RNS and HCAs are competent to apply and monitor restraint use. Education records are maintained by the restraint co-ordinator.

The service has a restraint/enabler register. The restraint register reviewed records the type of restraint, when commenced, review dates and when ceased. Restraint is only used as a last resort to maintain safety of the resident, staff and others.

The restraint evaluation form developed and implemented is comprehensive to ensure each restraint episode is evaluated to see if the intended outcome is achieved. Based on that outcome it will be decided if restraint is to be continued or not. The resident/relative is included in this evaluation and their feedback is encouraged. The care plan is updated if any changes are made or additional needs identified.

The DHB contract requirements are met.

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:

Restraint evaluations are conducted at least six monthly or sooner to reflect changes in the residents condition. The evaluation reviews was de-escalation attempted before restraint use, was the individual plan followed, is the outcome achieved, staff feedback, was anybody injured, time limits and interventions appropriate, correct procedures followed, least restrictive restraint option used, monitoring appropriate (form completed), debriefing/advocacy provided, cultural needs met, documentation satisfactory are all considered during the evaluation process. Any educational needs can be identified at this time as well.

The restraint co-ordinator maintains the education for all care staff and ensures she attends ongoing education in relation to restraint minimisation and safe practice by linking in with the Rural Health Professional Development Programme (video link) and attends DHB study days and attends ACC Lite Risk Assessment courses. A peer group in Waikato meet four to five times a year and discuss assessment tools, processes and exchange ideas on restraint minimisation and safe practice, falls and annual handling in health care settings. Alzheimer's Waikato held a study day on the 5 May 2014 on managing challenging behaviour and staff attended this session. Any changes required are added to the care plans as indicative to ensure they are up-to-date to guide care staff. Family/whanau are informed of any outcomes or changes and this is documented in the progress records and on the communication family record if required.

The DHB contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint minimisation and safe practice system is clearly linked to service delivery across the service, quality and risk management and health and safety systems in place for this organisation. The comprehensive pre-assessment process, approval and consent process, restraint monitoring on a daily basis, six monthly and earlier if and when required, evaluations and restraint monitoring and quality reviews are undertaken by the restraint co-ordinator. The development, approval by management and the implementation of a comprehensive restraint minimisation and safe practice system is well embedded in the service provided. Multidisciplinary meetings occur and restraint approval is discussed at this time by the approval group. Two weekly restraint meetings are held and any outcomes are discussed. Often this is an opportunity for some ongoing education to be provided as discussed with the restraint co-ordinator at interview. Quality review audits for 2013 and 2014 sighted evidence outcomes. The reports are prepared and presented to the Trust Board meetings held three monthly.

There is an area of continuous improvement identified in relation to restraint monitoring and quality review processes.

The DHB contract requirements are met.

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: CI

Evidence:

The restraint use quality review for individual restraint use – six monthly audits are conducted and discussed for each individual resident using a form of restraint/enabler. The audit criteria is comprehensive and any findings or comments are discussed at staff meetings. Any education required is considered and included on the education calendar as required or if the opportunity arises this is discussed at the staff meetings on a regular basis. The restraint approval group discuss the restraint use and any trends that may arise. The service is reducing the use of restraint and the use of restraint is reported monthly and presented at the quality meetings held two monthly. Management report to the Rangiura Trust Board three monthly. The Rangiura Trust board has taken this on board and increased the hours for the physiotherapist and a rehabilitation assistant has been employed for an additional three days a week to assist.

The physiotherapist/restraint co-ordinator at interview discusses having a restraint policy that endeavours to minimise restraint usage and one that is rigorously reviewed. An example of alternative strategies to restraint now in place include a resident rolling out of bed is usually managed by lowering an ultra-low bed then putting in place an impact and a sensor mat at the ends of the bed so timely help can be given rather than using bed rails that a resident with delirium or dementia can become tangled in. Other examples were discussed with the restraint co-ordinator.

The one resident in Fern Haven House using a restraint has alternative or de-escalation techniques identified in the care plan sighted (as do the other records reviewed). All care staff have to complete competencies annually and receive ongoing education and support. The education calendar reviewed is developed and implemented for 2014 and this includes restraint management.

The restraint co-ordinator ensures that the monitoring and observations are appropriate to the level of risk identified during the pre-assessment and evaluation processes and that interventions are clearly documented to guide staff. The progress towards a restraint free environment is encouraged balancing safety and risk. Restraint management is linked to the health and safety and quality and risk management system.

There is an area of continuous improvement identified that clearly demonstrates excellence for restraint monitoring, review and evaluations to improve the outcomes for residents using a form of restraint.

Finding:

Having fully attained the criterion the service can in addition clearly demonstrate excellence for restraint monitoring and quality review. The comprehensive quality review of individual restraint use performed six monthly or more often if required is well implemented by the experienced restraint co-ordinator. The audit criteria reviewed includes the review of the policies and procedures ensuring compliance with the Restraint Minimisation and Safe Practice Standard NZ8141 2008.

An individual assessment and planned approach is delivered and followed that complies with the service policies and procedures. The audit evidences, timely and appropriate ongoing resident/family/whanau communication. This is clearly verified in the progress records and on the communication family record in the front of the resident`s files sighted. Advocacy, support and cultural needs are verified and provided, written consent is obtained and forms are signed appropriately. Safety is paramount.

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:

Policies and procedures are available for staff detailing hand hygiene, and standard precautions and transmission based precautions. The policy details the incubation period/infectivity for a number of pathogens. The policy notes the influenza vaccination is offered to consenting residents on an annual basis. The infection control programme is last reviewed in January 2014. The quality management meeting was held to set the infection prevention objectives. Sixteen objectives identified have clear plans documented on how the objectives will be effectively met. Most are ongoing but clearly document who is responsible, by when and signed off when and if achieved.

The service has a process identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at the entrance to the rest home and hospital and dementia facility (Fern Haven). When outbreaks are identified in the community, notices are placed at the entrance not to visit this service if the visitor has come in contact with people or services that have outbreaks identified.

Sanitising hand gel is available throughout the facility and there is adequate hand washing facilities for staff, visitors and residents. Residents suffering from infectious diseases are isolated if required. Staff policy and notices in the staff room state not to come to work when suffering from infectious diseases. The seven of seven healthcare assistants interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing.

The DHB requirements are met.

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 infection prevention and control committee is established and consists of the infection control co-ordinator (ICC) who is a registered nurse, two enrolled nurses and another experienced registered nurse. The committee works closely with the health and safety team. The infection control co-ordinator implements the infection prevention control programme for the services provided. External specialist advice can be obtained through Bug Control senior advisor, the contracted pharmacist, the Ministry of Health (MOH) the microbiologist for a pathology laboratory services, the GP and/or Nurse Practitioner.

The DHB requirements are met.

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:

Infection prevention and control policies are available. The policies are dated as reviewed in February 2014 and are appropriate to the service setting and reflect current accepted practice. Policies and procedures include, hand hygiene, standard precautions, transmission-based precautions, prevention and management of infection in service providers, antimicrobial usage, outbreak management, cleaning, disinfection, single use items, renovations and construction. Implementation of the policies and procedures is observed during this onsite audit. Staff demonstrate safe and appropriate infection prevention and control practices. The seven of seven health care assistants, two registered nurses, two cleaners and two laundry staff, one cook and one kitchen hand at interview have a good understanding of the principles of infection control.

The DHB requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control co-ordinator (ICC) maintains education and attends ongoing additional education for the role of infection control co-ordinator. The ICC has a post graduate certificate in Infection Control. Recent examples of ongoing education include a comprehensive DHB infection control update day, a pandemic planning study day, bug control sessions and other educational sessions relevant for meeting the requirements for this role. Certificates and training record is available and reviewed for the ICC. The infection control co-ordinator at interview is very experienced and demonstrates a good knowledge base of current accepted good practice in infection prevention and control.

The infection control committee is updated on any infection control issues and each receive relevant infection control education to their role. The training calendar sighted evidences approximately six planned in-service educational sessions each year for staff and a self-directed learning package is also available. ACE training is provided in conjunction with the in-service education programme. The infection control co-ordinator maintains a record of all education provided to staff. Staff at interview reported they received infection control education at commencement of employment and education is ongoing.

Residents receive education as required and this is documented in the individual resident`s records on the progress notes.

The DHB requirements are met.

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 frequency and type is set out in Rangiura policy and is determined by the organisation`s infection control policies and procedures that are reflective of the services offered. The infection control surveillance policy (February 2014) identifies 'every infection is reported on infection report form, this information is collated monthly and reviewed and analysed by the infection control coordinator who will advise management of the outcome.' There are documented guidelines detailing the signs and symptoms that if present would be considered as the resident having an infection. The infections include urinary tract infections, lower respiratory tract infection, eye infections, gastroenteritis, skin and soft tissue, wound infections and scabies. A resident infection assessment form is in the front of each individual resident`s medication file sighted. Six rest home, six hospital and six dementia level individual medication files are available for review.

The surveillance data for 2013 and 2014 is available for review. The infection control co-ordinator explained the surveillance process. Information gained is clearly documented by the infection control co-ordinator. Any trends are highlighted and identified from the three service areas individually. The information is printed off electronically in graph form for all infections. The results are presented at the staff meeting, health and safety meeting and at the quality and risk meetings held two monthly. Meeting minutes are available. Training is provided at these meetings if indicative or as part of the infection control education programme.

The surveillance programme reviewed is appropriate for the size of the organisation and for the services provided.

The three of three registered nurses inclusive of the infection control co-ordinator interviewed and seven of seven healthcare assistants at interview report they understand and use the standardised definitions to report infections and that surveillance results are communicated effectively at staff meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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