Terrace View Lifecare Limited

Current Status: 4 September 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

TerraceView is a purpose built facility situated in Ashburton providing retirement village living, rest home and hospital level care. The service opened in November 2013. The service is certified to provide care hospital and rest home care for up to 64 residents within the complex. This includes providing care across 32 hospital/rest home beds, 11 care suites, 15 apartments, and six studio units. On the days of audit there were 42 residents requiring care – 26 rest home and 16 hospital beds.

The service has implemented a quality and risk management programme identifying quality improvements. The service is managed by an experienced village manager who is a registered nurse and is supported by registered nurses and care staff. The service provides care to residents based on the services mission and philosophy. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified that improvements required in relation to resuscitation orders, recording of time of entry and designation on documentation, ensuring care plan documents are signed by a registered nurse, conducting assessments where required, ensuring short term care plans are utilised fully and dating of decanted foods.

Audit Summary as at 4 September 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 4 September 2014

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

Organisational Management as at 4 September 2014

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

Continuum of Service Delivery as at 4 September 2014

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

Safe and Appropriate Environment as at 4 September 2014

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

Restraint Minimisation and Safe Practice as at 4 September 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 4 September 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 4 September 2014

Consumer Rights

There are systems in place to ensure residents and their family are provided with information to assist them to make informed choices and give informed consent. Staff interviews confirm staff have understanding of informed consent processes. Residents and family state they have been made aware of and understand the informed consent processes and that appropriate information is provided. There is an area requiring improvement around 'not for resuscitation orders'.

Organisational Management

Terrace View has a business plan and a quality and risk management programme that outlines objectives and goals. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff and quality meetings which include health and safety and infection control. Residents and relatives are provided the opportunity to feedback on service delivery issues at resident meetings and at care plan review meetings. Annual satisfaction surveys have yet to be conducted. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. TerraceView has job descriptions for all positions that include the role and responsibilities of the position. A comprehensive orientation programme was implemented for all new staff and an in-service training programme is provided. Care staff completed the ACE training programme prior to opening. Staff are supported to undertaken external training. There is a plan to conduct annual performance appraisals. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. Improvements are required whereby staff record time of entry on progress notes and all care planning documents are signed and dated.

Continuum of Service Delivery

Terrace View has documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Residents or their family have input into the development and review of care plans. There are areas requiring improvement around signing of the initial care plan, and short term care plans.

The registered nurse develops, updates and evaluates the residents' long term care plans at least six monthly. Residents interviewed state they are satisfied with the standard of care provided by staff and that interventions noted in their care plans are consistent with meeting their needs.

There is a planned activities programme that involves residents in the community and in house. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. Residents interviewed confirm the programme is varied and they can choose what they would like to participate in.

There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and staff medication competencies are current. Residents' medication charts are legible, up to date and reviewed by the general practitioner three monthly or earlier if required.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Changes to residents' dietary needs are communicated to the kitchen and special diets are noted. Residents confirm satisfaction with the meal service and that adequate fluids are provided and snacks are available between meals. Kitchen staff have completed food safety training. There is an area requiring improvement around dating of decanted foods.

Safe and Appropriate Environment

There are documented policies and procedures for the management of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff.

Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as staff. Communal areas have furniture that is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. External areas are available for sitting and shading is provided.

All residents' bedrooms have full ensuites. There are visitor's toilets and communal toilets conveniently located close to communal areas. Residents are able to access areas for privacy, if required.

Documented policies and procedures for cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There is safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

Restraint Minimisation and Safe Practice

The service has policies and procedures in place in line with restraint standards. One rest home resident is assessed as requiring an enabler (bedrails) and no residents are requiring restraint. Restraint education and competencies have been completed. The service has completed appropriate assessment, consent, planning and monitoring of the enabler in use.

Infection Prevention and Control

The infection control nurse is a registered nurse with post graduate qualifications in infection prevention and control. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is to be reviewed annually. Infection control education is provided for staff on orientation and as part of the education programme. Infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to staff and quality meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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:	Terrace View Lifecare Limited
Certificate name:	Terrace View Lifecare Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	Terrace View Retirement Village
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 4 September 2014 **End date:** 5 September 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:	42

Audit Team

Lead Auditor	XXXXX	**Hours on site**	12	**Hours off site**	5

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	XXXXXX			**Hours**	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	11	Total audit hours	35

Number of residents interviewed	14	Number of staff interviewed	13	Number of managers interviewed	1
Number of residents' records reviewed	8	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	17	Total number of staff (headcount)	47	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Tuesday, 14 October 2014

Executive Summary of Audit

General Overview

TerraceView is a purpose built facility situated in Ashburton providing retirement village living, rest home and hospital level care. The service opened in November 2013. The service is certified to provide care hospital and rest home care for up to 64 residents within the complex. This includes providing care across 32 hospital/rest home beds, 11 care suites, 15 apartments, and six studio units. Forty three of these rooms can be utilised for dual purpose beds (rest home or hospital level). On the days of audit there were 42 residents requiring care – 26 rest home and 16 hospital.

The service has implemented a comprehensive quality and risk management programme identifying quality improvements through a variety of activities. The service is managed by an experienced village manager who is a registered nurse and is supported by registered nurses and care staff. Registered nurses are on duty on each shift. The village manager reports that staffing levels are established and that turnover is low. The service provides care to residents based on the services mission and philosophy. Staff interviewed and documentation reviewed identify the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified that improvements required in relation to resuscitation orders, recording of time of entry and designation on documentation, ensuring care plan documents are signed by a registered nurse, conducting assessments where required, ensuring short term care plans are utilised fully and dating of decanted foods.

Outcome 1.1: Consumer Rights

There are systems in place to ensure residents and their family are provided with information to assist them to make informed choices and give informed consent. Staff interviews confirm staff have understanding of informed consent processes. Residents and family state they have been made aware of and understand the informed consent processes and that appropriate information is provided.

There is an area requiring improvement around ‘not for resuscitation orders’.

Outcome 1.2: Organisational Management

TerraceView has a business plan and a quality and risk management programme that outlines objectives and goals. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff and quality meetings which include health and safety and infection control. Residents and relatives are provided the opportunity to feedback on service delivery issues at resident meetings and at care plan review meetings. Annual satisfaction surveys have yet to be conducted. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. TerraceView has job descriptions for all positions that include the role and responsibilities of the position. A comprehensive orientation programme was implemented for all new staff and an in-service training programme is provided. Care staff completed the ACE training programme prior to opening. Staff are supported to undertaken external training. There is a plan to conduct

annual performance appraisals. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. Improvements are required whereby staff record time of entry on progress notes and all care planning documents are signed and dated.

Outcome 1.3: Continuum of Service Delivery

Terrace View Life has a documented entry criteria, which is communicated to residents, family and referral agencies.

Systems are implemented that evidence each stage of service provision has been developed with resident and/or family input and is coordinated to promote continuity of service delivery. Residents or their family have input into the development and review of care plans. There are areas requiring improvement around signing of the initial care plan, and short term care plans.

The registered nurse develops, updates and evaluates the residents' long term care plans at least six monthly. Residents interviewed state they are satisfied with the standard of care provided by staff and that interventions noted in their care plans are consistent with meeting their needs.

There is a planned activities programme that involves residents in the community and in house. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. Residents interviewed confirm the programme is varied and they can choose what they would like to participate in.

There is an appropriate medicine management system in place. Staff responsible for medicine management have attended in-service education for medication management and staff medication competencies are current. Residents' medication charts are legible, up to date and reviewed by the general practitioner three monthly or earlier if required.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Changes to residents' dietary needs are communicated to the kitchen and special diets are noted. Residents confirm satisfaction with the meal service and that adequate fluids are provided and snacks are available between meals. Kitchen staff have completed food safety training.

There is an area requiring improvement around dating of decanted foods.

Outcome 1.4: Safe and Appropriate Environment

There are documented policies and procedures for the management of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff.

Documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids as well as staff. Communal areas have furniture that is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. External areas are available for sitting and shading is provided.

All residents' bedrooms have full ensuites. There are visitor's toilets and communal toilets conveniently located close to communal areas. Residents are able to access areas for privacy, if required.

Documented policies and procedures for cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There is safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

Outcome 2: Restraint Minimisation and Safe Practice

The service has policies and procedures in place in line with restraint standards. One rest home resident is assessed as requiring an enabler (bedrails) and no residents are requiring restraint. Restraint education and competencies have been completed. The service has completed appropriate assessment, consent, planning and monitoring of the enabler in use.

Outcome 3: Infection Prevention and Control

The infection control nurse is a registered nurse with post graduate qualifications in infection prevention and control. The service has infection control policies provided by Bug control and an infection control manual to guide practice. There is an infection control programme that is to be reviewed annually (due October 2014). Infection control education is provided for staff on orientation and as part of the education programme. Infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to staff and quality meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	39	0	6	0	0	0
Criteria	0	87	0	6	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	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		family/whānau of choice are provided with the information they need to make informed choices and give informed consent.				
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	'Not all resuscitation' records are recorded and GP sign off is not consistently recorded on the resuscitation orders. 'Not for resuscitation' orders are not consistently signed by GPs (four of eight files, two rest home and two hospital) and one of eight files (one rest home) evidences the 'not for resuscitation' record is not completed. The facility policy states the GP verifies if a resident is competent to make a resuscitation decision.	Provide evidence the GP assesses and documents the resident is competent to make resuscitation decisions.	90
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	In seven of eight files reviewed, there are inconsistent recordings of time of entry in progress notes and inconsistent	Ensure that all entries in progress notes include the time of entry and designation of person making the entry.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				recording of designation of person making the entry.		
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.1	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.	PA Low	The initial care plan is completed by an enrolled nurse (EN) and not checked and countersigned by registered nurse (RN), as per ARC contract D16.2b and D16.3b.	Provide evidence the initial care plan completed by an enrolled nurse is reviewed and countersigned by a RN.	90
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The initial care plans do not include spiritual and cultural aspects of care (ARC contract D16.2a). Risk assessments are not consistently conducted when required. Seven of eight resident files (three hospital and	Provide evidence of a full assessment process for all residents.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				four rest home) with pain issues do not evidence completion of pain assessments. Respite care resident's file does not evidence completion and documentation of any risk assessments.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Short term care plans are not consistently conducted for short term problems. Two of five short term care plans reviewed do not evidence detailed planned intervention related to the short term problem.	Provide evidence short term care plans are recorded for short term problems and interventions are detailed to guide care relating to the short term problems.	60
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and	PA Low	Decanted foods are not dated.	Provide evidence decanted foods are dated.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		guidelines.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

There is a consumer rights policy. Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. On interview all staff – two caregivers, two enrolled nurses, three registered nurses and the village manager were aware of consumer's rights and were able to describe how they incorporated consumer rights within their service delivery. The Code of Rights is discussed with new residents and a copy is provided in the information pack. Fourteen residents (ten rest home and four hospital) and four family members (two rest home and two hospital) interviewed spoke highly of the staff's respect of all aspects of the code of rights. Code of rights, advocacy, privacy and informed consent training was held during the three day orientation and training programme for new staff prior to opening in November 2013.

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:

There are posters of the code of rights on display and leaflets available in the reception area of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (two caregivers, two enrolled nurses, three registered nurses and the village manager stated that they take time to explain the rights to residents and their family members. Fourteen residents (ten rest home and four hospital) and four relatives (two rest home and two hospital) confirmed that they had received information about their rights on entry to the service and that gain their consent prior to cares being provided.

Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the village manager or RN discuss the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy. Health and disability advocacy service leaflets are also available from the reception area. The information pack provided to residents on entry includes how to make a complaint, informed consent, code of rights, interpreter services, advocacy and H&D Commission information.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All 14 residents and four family members interviewed indicated staff were highly respectful and maintained resident's privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training was held in November 2013 as part of the comprehensive orientation for all new staff.

The resident's initial assessments and care plans are noted not to detail their cultural needs, values, ethnicity and spiritual beliefs (link #1.3.4.2). All 14 residents interviewed stated their needs were met. All eight resident files reviewed (three rest home, four hospital and one rest home respite), have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There is a policy that describes resident's spiritual care. There are various churches locally and residents are encouraged to attend these. Multidenominational services are conducted in the facility at least twice a month. All residents and family members interviewed indicated that resident's spiritual needs are being met when required. On interview all 14 residents (10 rest home and four hospital) stated staff respect their rights. The service includes emotional wellbeing in the long term care planning process.

Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered and discussed openly. On interview all 14 residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview two caregivers, two enrolled nurses and three registered nurses described how they encouraged residents to engage in activities in the facility and to link with community activities including church, service clubs and support groups.

There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at the staff three day orientation and training days held in November 2013. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Discussions with

staff identified that there have been no episodes of abuse of neglect at the facility. Fourteen residents and four family members interviewed were complimentary of the care provided and stated staff were very caring, approachable and friendly.

The service has a philosophy that respects the uniqueness and fosters the potential of each individual resident, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

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 service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.

Staff training includes cultural safety and awareness at orientation. Cultural safety in-service training was provided as part of the three day orientation and training days held in November 2013. There are currently no residents who identify as Maori. TerraceView identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the RN's, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual's service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with two caregivers, two enrolled nurses, three registered nurses and one village manager confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately. There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e) of the ARC contract. The service has developed a link with local Maori organisations and iwi (Ngai tahu).

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 service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. All residents currently at the service are English speaking.

Family are involved in assessment and the care planning process. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.

The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs

Long term care plans reviewed included the resident's social, spiritual, cultural and recreational needs

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The facility has a policy that determines a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover physical, psychological and emotional abuse and cultural abuse. All residents interviewed reported that the staff respected them. Elderly abuse prevention training occurs at orientation and as part of code of rights training and includes professionalism and standards of conduct. Code of rights and abuse and neglect in-service training was last held in November 2013 as part of the three day orientation and training programme for new staff. The RN's supervise staff to ensure professional practice is maintained in the service.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The caregivers are encouraged to complete Aged Care Education programme NZQA level training and an internal in-service training programme is implemented. The village manager and registered nurses attend external training sessions appropriate for their positions.

Services are provided at the facility that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. All approved service standards are adhered to. There are implemented competencies for RN's and EN's. There are clear ethical and professional standards and boundaries within job descriptions

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. The sample of incidents/accidents reports reviewed for August 2014 all included a completed section where family notification has been recorded. There are family contact sheets in each residents file. TerraceView has an open disclosure policy. On interview 14 residents (ten rest home and four hospital), four family members (two rest home and two hospital) all stated that family are informed following changes in the resident's health status.

The village manager and three registered nurses interviewed stated that they record contact with family/whanau in resident's files. Contact records were documented in all eight resident files reviewed.

A residents/relative meeting occurs monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.

There is a policy that describes the availability of interpreter services when required.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Eight residents' files sampled (five rest home and three hospital) record documented informed consent within the residents' admission agreements. The advance directive and not for resuscitation orders are recorded on a separate form. Additional consents are obtained for treatment and care as required, such as consent for flu vaccinations, sighted in resident files reviewed.

All eight admission agreements sampled are signed by a resident or their legal representative and a facility representative. Discussions with 14 residents (10 rest home and four hospital) and four family (two rest home and two hospital) identify that the service actively involves them in decisions that affect their lives.

Seven clinical staff (two caregivers, two enrolled nurses (ENs) and three registered nurses (RNs)) and the manager interviews confirm that they are familiar with the requirements relating to informed consent.

There is an area requiring improvement around not for resuscitation orders.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

The resident's informed consent is recorded within the resident's admission agreement. The advance directive and not for resuscitation orders are recorded on a separate form. Additional consents are obtained for treatment and care as required, such as consent for flu vaccinations, sighted in resident files reviewed. The resident's admission agreements are signed by a resident or their legal representative and a facility representative. Interviews with residents and family identify that the service actively involves them in decisions that affect their lives.

Finding:

'Not all resuscitation' records are recorded and GP sign off is not consistently recorded on the resuscitation orders. 'Not for resuscitation' orders are not consistently signed by GPs (four of eight files, two rest home and two hospital) and one of eight files (one rest home) evidences the 'not for resuscitation' record is not completed. The facility policy states the GP verifies if a resident is competent to make a resuscitation decision.

Corrective Action:

Provide evidence the GP assesses and documents the resident is competent to make resuscitation decisions.

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an advocacy policy. Staff receive training on advocacy services. Advocacy in-service training was last held in November 2013. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with two enrolled nurses and two caregivers, 14 residents and four family members informed they are aware of advocacy and how to access an advocate.

Discussion with family members identified that the service provides opportunities for the family/EPOA to be involved in decisions. There is a care plan review meeting held six monthly for each resident with family involvement.

The resident file includes information on resident's family/whānau and chosen social networks.

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:

Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff (two caregivers, two enrolled nurses, three registered nurses, and the village manager) stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. The facility engages with other local facilities that provide similar services. Discussion with four family members stated that they are encouraged to be involved with the service and care.

Residents and families interviewed confirm that they are supported and encouraged to remain involved in the community and external groups such as churches, service clubs, and social groups such as Rotary, RSA and Rural women.

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 service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about the complaints process is provided on admission. Interview with 14 residents (ten rest home and four hospital) and four family members (two rest home and two hospital) inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints

There is a complaints register. The service has received one complaint since opening in November 2013. This related to a family generated complaint around perceived care and services for a resident. The complaint has been recorded in the register as resolved. The complaint has been investigated with response recorded including meetings and discussion with family and staff.

Discussions with 14 residents and four family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with two caregivers and two enrolled nurses confirmed that concerns/complaints would be discussed at staff meetings and meeting minutes available in the staff room.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

TerraceView is a purpose built facility situated in Ashburton, providing retirement village living, rest home and hospital level care. The service opened in November 2013 and is certified to provide care to 64 residents within the complex. The retirement village includes 32 hospital/rest home rooms, 11 care suites, 15 apartments, and six studio units. Forty three of the 64 beds can be used as dual-purpose.

The studio units, care suites, serviced apartments and specific rest home and hospital rooms are within one complex with a central nurses station and reception area. There are 25 rest home and 10 hospital residents in the rest home/hospital area including one rest home respite resident; four hospital residents in the care suites; one rest home and two hospital residents in the apartment wing; and no assessed residents in the studio units. The remaining units are occupied by retirement village residents.

TerraceView is jointly owned by the village manager and another shareholder. Both are governing directors of the village. The village manager is a registered nurse. She has managed and owned rest homes and hospital continuing care facilities for over twenty years, along with retirement villages. Governance is provided by an appointed board of directors including the two owners, which meets two monthly with discussion held around occupancy, quality and risk, staffing and finances.

TerraceView has a business plan for 2013 – 2018 and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The annual quality plan and risk management plan includes an audit plan, education plan, incident and accident reporting, with an analysis completed monthly for the quality meeting.

The philosophy of the organisation includes: "providing residents with autonomy, dignity and choice in their daily lives in an innovative, empathic and holistic manner; valuing and respecting our residents and their extended family but we also value each member of our team by helping them continue to attain and apply knowledge in the "art' of providing care and services; by doing this we will never lose sight of whom we are ultimately accountable to residents".

The village manager is suitably qualified and is supported by a registered nurses, the board of directors and the other owner. The village manager has attended a three day aged care conference, a retirement village conference, palliative care lecture series, and an aged care forum and is an executive member of the aged care association.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the absence of the village manager, the senior registered nurse the management of TerraceView. A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality

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 facility has a quality framework that is being implemented. The village manager is directly involved in operations at the facility and the senior registered nurse, and nursing team support the village manager in this role. There is a business plan in place for 2013 – 2018 that includes objectives/goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. The current quality programme and risk management plan objectives includes but

not limited to; quality improvement activities, nursing, infection control, risk management and health and safety. Interviews with all staff (two caregivers, two enrolled nurses, three registered nurses, and the village manager, inform an understanding of the quality activities undertaken at TerraceView.

Resident/relatives meetings occur monthly with discussion recorded around nursing cares, housekeeping and laundry, activities, meals and heating. Fourteen residents and interviewed (ten rest home and four hospital) and four relatives, are aware meetings are held. Annual satisfaction surveys are to be undertaken – planned for October 2014. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service.

Policies and procedures are in place with evidence of review. The village manager, senior registered nurse and heads of departments manage quality systems. The quality programme is due to be reviewed in October 2014. Information is reported through the two monthly staff meetings and two monthly quality meetings. Meetings discus key components and standing agenda items of the programme include complaints and compliments, human resources and education, risk management, restraint, maintenance and gardens, nursing issues, audits, infection control, hazards, laundry, housekeeping, food service, report from resident meetings, administration and policy and procedure review. Documentation no longer in use is archived in a locked cupboard.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that will be reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented.

There is an annual internal audit programme. Audit conducted so far since the service opened include pharmaceuticals, security, laundry, resident cares, workplace hazard inspection, kitchen and food service, waste management, air and hot water temperature monitoring, housekeeping, hand washing and a comprehensive clinical/medical records audit. Medication management audit is due in September 2014. Corrective actions are discussed at quality meetings, are documented and sighted as resolved. Results and outcomes of audits are discussed in quality and staff meetings (sighted for 22 July 2014).

Quality data that is collected by way of infection reports, incident reports, hazards, complaints and compliments, internal audits, meeting minutes and feedback from residents, families and staff. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. Quality improvement initiatives currently underway include a falls prevention programme which includes exercises, education for staff and residents and reading material and information available in the foyer.

TerraceView has policies and procedures that describe the management of risks. There is a hazard register for each area of the service. Hazard forms are available for use and are seen to be well utilised. Two caregivers and two enrolled nurses interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

Falls prevention strategies such as the use of sensor pads, hip protectors, walking frames, physiotherapy assessment, and falls risk assessments and use of standing hoists are in place.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)
Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)
A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an accident/incident reporting policy and procedures. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by a health and safety representative, the senior registered nurse and the village manager - who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and quality meetings.

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.

A sample of 14 incidents/accident reporting forms (of 33) for August 2014 were viewed and related to five residents – two hospital and three rest home. The incidents reviewed included falls, behaviours, and a skin tear, and two medication errors. The facilities policy and procedure on incident management were implemented. Residents (ten rest home and four hospital) and relatives (two rest home and two hospital) interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. Copies of relevant incident forms are held in the clinical files. All adverse events are analysed monthly and included in the quality meetings. Graphing of incidents and accidents is completed each month in relation to skin tears, falls, behaviours, medication errors, property damage, bruising and other.

There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

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:

TerraceView employs 47 staff and there are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of registered nurses and enrolled nurses are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist, dietitian, podiatrist and physiotherapist. Appointment documentation is seen in seven staff files sampled (two registered nurses, one enrolled nurse, two caregivers, one activities coordinator, and one cook) including signed contracts, job descriptions, orientation, practicing certificates, reference checks and training. There is an annual appraisal process yet to be implemented as all staff commenced employment within the last 10 months.

The service provided a comprehensive three day training programme for all new staff prior to opening as well as providing a five week ACE training programme for all new caregivers. New staff employed since opening also have a comprehensive orientation which includes at least three days orientation and working with a senior staff member. The orientation programme includes but not limited to, fire training and evacuation training, health and safety, and infection control. Interviews with two caregivers, two enrolled nurses, three registered nurses, one cook, two laundry staff, one housekeeper and one activities coordinator described the orientation programme. The service has a training policy and schedule for in-service education. The in- service schedule is implemented and attendance recorded at sessions kept. The senior registered nurse is responsible for the ACE training programme. Eleven of 14 caregivers have completed the level three programme with the remaining three staff working towards this qualification. The three day training and orientation programme provided in November 2014 (prior to occupancy) included consumer rights, advocacy, restraint, cultural awareness, abuse and neglect, fire training, human resource policies, infection control and hand hygiene, and safe chemical handling. Records were viewed for attendance for the orientation programme and the in-service education sessions. Further education has been provided including (but not limited to): first aid 16, Ecolab 5; care of hearing aids 10, hoists and back care 13, wound care 26, medications 9, Liverpool care pathway 12, continence 5, and syringe driver training for EN's and RN's. A palliative care lecture series is also provided once a month which all care staff are encouraged to attend. Interviews with two caregivers, two enrolled nurses, and three registered nurses confirm there is access to sufficient training. The annual training programme exceeds eight hours annually. Medication competencies are required to be completed for all RN's, EN's and senior care staff who administer medication (sighted). Registered nurses also complete two yearly syringe driver training and competency.

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The roster covers all areas and includes staff working a roster of four days on and two days off. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The senior registered nurse covers the village manager during absences and holidays. Residents and relatives interviewed stated they felt there are sufficient staff to meet the needs of residents.

There is an RN on duty 24 hours per day. A contractor physiotherapist attends the facility for two half day sessions per week with one caregiver trained as a physiotherapist assistant.

The village manager works 40 hours per week and is available after hours for clinical and non-clinical issues. The service employs a full time maintenance person. There is one RN on each shift as well as caregivers working long and short shifts. The serviced apartments and studio units have another caregiver on in the morning for retirement

village residents. There is a minimum of one RN and one caregiver on duty overnight. The nurses station is located in the centre of the care centre and all resident areas are easily accessible for staff to attend to residents call bells. Kitchen staff includes cooks and kitchen hands and there are designated activities staff, laundry and cleaning staff.

All rosters allow for hand-over time. The rosters provide sufficient and appropriate coverage for effective delivery of care and support for the full facility. The service does not have access to bureau staff

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: PA Low

Evidence:

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate). All resident files are hard copy files. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident's files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and hospital residents. The service keeps a resident register.

TerraceView has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the locked nurses' stations. Old files are individually archived and locked in a secure area. Records can be accessed only by relevant personnel.

Resident documents including care plans and progress notes are signed and dated by the staff member recording the information. Medical notes and allied health input are signed and dated appropriately. Improvements are required whereby entries in progress notes include time of entry and designation of staff member making the entry.

Improvement note: the service may consider maintaining a record or register of staff and medical personnel names, designation and signatures for clear identification of person making entries.

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: PA Low

Evidence:

TerraceView has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards. Medical notes and allied health input are signed and dated appropriately. Resident documents including care plans and progress notes are signed and dated by the staff member recording the information. And includes time of entry and designation. Medical notes and allied health input are signed and dated appropriately.

Finding:

In seven of eight files reviewed, there are inconsistent recordings of time of entry in progress notes and inconsistent recording of designation of person making the entry.

Corrective Action:

Ensure that all entries in progress notes include the time of entry and designation of person making the entry.

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

Criterion 1.2.9.10 (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:

Policy and procedures for entry to services are recorded and implemented. The manager interview confirms access and entry processes are followed. There is a facility information pack available for residents and their family. Resident information pack is sighted and contains all relevant information.

Resident files sampled demonstrate all needs assessments are completed for either rest home or hospital level of care.

Interviews with 14 residents (10 rest home and four hospital) and four family (two rest home and two hospital) confirm the admission process was conducted by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.

The service provides information to potential referral sources. This facility operates 24 hours a day, seven days per week. The admission agreement defines scope of service and includes all contractual requirements.

Eight residents' files (five rest home and three hospital) were sampled. All residents' admission agreements sampled evidence residents' and facility representative sign off.

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:

Systems to decline resident entry to the service are documented. The scope of the service is identified and communicated to all concerned. A process to inform resident in an appropriate manner, of the reasons why the service has been declined will be implemented, if required, stated by the manager. The manager states resident will be declined entry if not within the scope of the service or if a bed is not available at the time.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

In the resident files sampled (eight of eight), there is evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) is conducted with resident and/or family input, within required timeframes and the service is coordinated to promote continuity of service delivery.

Clinical staff (three registered nurses (RN), two enrolled nurses (EN) and two care givers) interviews confirm residents and/or family members are involved in all stages of service provision. Fourteen residents (ten rest home and four hospital) interviews confirm their input into assessment, service delivery planning and care evaluations. All eight resident files evidence there is integration of allied health personnel and a team approach to service delivery.

The residents' files sampled demonstrate the long term care plans are developed by the RN, signed off by the resident and/or family member and demonstrate team approach into reviews and evaluations.

Family communication sheets are maintained, sighted in all residents' files reviewed.

Copies of the registered nurses, GPs and other allied health providers practising certificates are kept on file by the management team.

All resident files reviewed identify that the general practitioner (GP) had seen the resident within two working days of the resident's admission to the facility. It was noted in all resident files sampled that the GP has assessed the resident as stable and able to be seen one or three monthly. The GP visits the facility once a week or more frequently as required, confirmed at GP interview.

An initial care plan is individually developed on admission.

Two of two caregivers, three of three registered nurses interviewed describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed. The auditor evidenced verbal briefing from morning to an afternoon shift.

General practitioner (GP) interview was conducted and confirms the GP has been providing medical services for the facility for since the facility opened in November 2013. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner and GP prescribed treatments are followed by staff.

There is an area requiring improvement around initial care plans to be signed off by a RN if completed by an enrolled nurse.

Tracer Methodology Hospital

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

Tracer Methodology Rest Home.

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: PA Low

Evidence:

Initial care plans are conducted on admission to the facility. Interviews with staff confirm staff receive training and education relating to care services and in their view they are competent to carry out their duties relating to their positions.

Finding:

The initial care plan is completed by an enrolled nurse and not checked and countersigned by RN, as per ARC contract D16.2b and D16.3b.

Corrective Action:

Provide evidence the initial care plan completed by an enrolled nurse is reviewed and countersigned by a RN.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The initial care plan is completed on admission, evidenced in all eight residents' files reviewed.

The service has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. Policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.

The residents' files sampled evidence residents' discharge/transfer information from DHB or other health provider (NASC) assessments are available. The facility has appropriate resources and equipment. The RN interviews confirm that assessments are conducted in a safe and appropriate setting including visits from the doctor.

Risk assessments include (but not limited to) continence assessment, mobility assessment, nutrition assessment, pain assessment, falls risk assessment, medical, pressure risk assessment and behavioural assessments.

There are areas requiring improvement around contents of initial care plan and completion of risk assessments.

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

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

Attainment and Risk: PA Low

Evidence:

Eight residents' files reviewed (five rest home and three hospital). There is evidence of completion of long term care plans within the required timeframes. The long term care plans record residents' needs, goals and interventions.

Finding:

The initial care plans do not include spiritual and cultural aspects of care (ARC contract D16.2a). Risk assessments are not consistently conducted when required. Seven of eight resident files (three hospital and four rest home) with pain issues do not evidence completion of pain assessments. Respite care resident's file does not evidence completion and documentation of any risk assessments.

Corrective Action:

Provide evidence of a full assessment process for all residents.

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

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

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

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

Attainment and Risk: FA

Evidence:

The residents' files sampled evidence residents' care plans are individualised and up-to-date. The resident's goals are identified and reviewed at regular intervals, at least six monthly or as needs change. Residents have input into their care planning and review, confirmed at all resident interviews. Clinical staff interviewed confirm that care plans are accurate and up to date.

Residents' files sampled evidence the clinical care/treatment/support or interventions that are to be provided by staff are current, the risk assessment findings are recorded on the care plans (refer to criterion 1.3.4.2). The facility ensures access to regular GP care, confirmed at GP interview. The long-term care plan is completed within three weeks of resident's admission to the facility.GP involvement occurs within 48 hours of resident's admission.

Service delivery plans demonstrate service integration and input from allied health.

Fourteen resident and four family interviews confirm care delivery and support by staff is consistent with their expectations.

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:

Eight resident (five rest home and three hospital) files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans sampled. GPs documentation and records are current.

The service provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. There is a short-term care plan that is used for acute or short-term changes in health status (refer to criterion 1.3.8.3).

Dressing supplies are available and a treatment room is stocked for use, sighted.

Continence products are available. Continence assessments and continence products identified for day use, night use, and other management are completed on admission. Specialist continence advice is available as needed and this could be described.

The wound folder is reviewed and evidences wound assessments and wound management plans are recorded for all current wounds. There are five wounds treated at the facility on audit days; three chronic ulcers, one skin tear and one laceration.

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 an activities coordinator (AC) employed at the facility and commenced employment in November 2013. Interview with the AC is conducted and confirms the activities programme meets the needs of the service group and the service has appropriate equipment. Residents' activities attendance records are maintained, sighted.

Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned / spontaneous activities including festive occasions and celebrations. There are interdenominational church services at the facility.

Residents' meetings are conducted.

Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being.

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: PA Low

Evidence:

There is documented evidence that the long term care plans were reviewed by registered nurses.

A review of eight resident files identify that reassessment by the registered nurse of assessment tools are completed at least six monthly and more frequently when health status changes.

There is at least a three monthly review by the GP. Care plans are evaluated by the registered nurses six monthly or when changes to care occur.

Interviews with residents and family confirm consultation and participation in care plan evaluations.

There is an area requiring improvement around completion of short term care plans for short term problems.

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: PA Low

Evidence:

Family interviews confirm staff inform them of any changes in their relative's condition. The GP interview confirms staff inform them of any resident's change in condition in timely manner. Residents' long term care plans are current and details appropriate interventions required.

Finding:

Short term care plans are not consistently conducted for short term problems. Two of five short term care plans reviewed do not evidence detailed planned intervention related to the short term problem.

Corrective Action:

Provide evidence short term care plans are recorded for short term problems and interventions are detailed to guide care relating to the short term problems.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service provider's documentation evidences appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services.

The residents' files sampled evidence completed referral forms / letters to demonstrate resident referral to and from other services is conducted when required e.g. DHB specialists. The residents' files sampled evidence family communication sheets document family involvement and facility communication with them, as appropriate. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

The residents' files evidence appropriate communications between family and other providers and demonstrate transition, exit, discharge or transfer plan is communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form / letters / plan are located in residents' files.

The policy and procedures describes guidelines for death, discharge, transfer, documentation and follow up. One resident's file where the resident had been transferred to hospital acutely, evidences appropriate transfer documentation. All relevant information is documented and communicated to the receiving health provider or service.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The medication area in the facility evidences an appropriate and secure medicine system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug storage area is secure. The controlled drug register is maintained and evidences weekly checks and six monthly stock takes. The medication fridge temperature checks are conducted and recorded.

Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given).

Medication round is observed and evidences staff are knowledgeable about the medicine administered and sign off, as the dose is administered.

Staff education in medicine management was conducted in March 2014.

Seventeen medicine charts are sampled (11 rest home and six hospital). All 17 medication charts demonstrate residents' photo identification, medicine charts are legible, PRN medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs.

All staff who administer medicines have current medication competency assessments. There are eight RNs, two ENs and 11 care givers who have been assessed as competent to administer medicines.

There is a self-medicating residents' policy available to guide staff practice. There are three residents who self-administer medication. The three monthly competency review for residents self -administering medicines are conducted. Medicines are stored safely. Interview with two of three residents who self- administer medicines were conducted and confirm residents' understanding and competency to self -administer medicines.

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: PA Low

Evidence:

The food service is provided on site. The service has a kitchen manual and four weekly rolling menu is implemented and changes seasonally. The menu review was conducted by a dietitian in June 2014.

The residents' nutritional profiles are assessed on admission and a copy is sent to the kitchen, confirmed at staff interviews. Kitchen staff are aware of resident's likes and dislikes, confirmed at cook interview. There is evidence of modified diets being provided e.g. diabetic menu and further nutritional supplements.

Food temperatures are conducted and recorded, sighted. Staff handling food have attended food safety training.

Fridge, freezer and chiller temperatures are monitored and documented. Food in the chiller and freezer are covered and dated.

Residents' files sampled demonstrate monthly monitoring of individual resident's weight. All eight resident's files record residents' nutritional needs and interventions on residents' care plans.

Residents and family interviewed are satisfied with the food service provided, report their individual preferences are well catered and adequate food and fluids are provided.

There is an area requiring improvement for decanted foods to be dated.

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: PA Low

Evidence:

There is adequate dry storage and pantry area. All food storage items are placed off the floor. The kitchen area was observed to be clean and tidy. The cleaning schedules are adhered to.

Finding:

Decanted foods are not dated.

Corrective Action:

Provide evidence decanted foods are dated.

Timeframe (days): 90 *(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:

Documented processes for the management of waste and hazardous substances are in place.

Chemical are labelled and labels are clear, accessible to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances, conducted by external supplier (Ecolab).

There is provision and availability of protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons and masks. Clothing is provided and used by staff. The sluice rooms is available for the disposal of waste and hazardous substances.

Staff training in chemical safety was conducted during staff orientation prior to occupancy and in June 2014.

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

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

Attainment and Risk: FA

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:

Maintenance person interviewed confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place. The maintenance person works full time, Monday to Friday and on call after hours, confirmed at maintenance person's interview. All equipment used (medical and electrical) is newly purchased prior to the facility opening in November 2013. The manager and the maintenance person interview confirms calibration of medical equipment and electrical checks of electrical equipment is planned for October 2014.

Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment e.g. hoists competency, confirmed at interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment and they are competent to use the equipment. The required equipment for care delivery such as shower chairs, electric beds are available. The facility has a van for transportation of residents and this vehicle has current warrant of fitness and registration.

The building holds a compliance schedule which expires on 24 January 2015, sighted and displayed at entrance to the facility.

There is sufficient space for residents to move around the facility freely. The hallways are wide enough with handrails appropriately placed. The residents were observed moving freely with walking aids and independently throughout the facility. There are quiet sitting areas in different parts of the facility. External areas safe. There are grassed areas around the building and outdoor seating with shade. Some external areas are sighted to be restricted for access due to landscaping.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All residents' bedrooms have full ensuites. There is an adequate number of communal toilets conveniently located close to communal areas.

The ensuites and communal toilet facilities are of an appropriate design and access that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two staff. Communal toilet facilities have a system that indicates if it is engaged or vacant. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).

Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are made available to promote resident independence.

Fourteen residents (10 rest home and four hospital) interviewed and four family (two rest home and two hospital) interviewed report that there are sufficient toilets and showers.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is one double room which is occupied by a married couple. There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Fourteen residents (10 rest home and four hospital) interviewed all spoke positively about their rooms. Residents' rooms are individually personalised.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Adequate access is provided to lounges, dining rooms, and other communal areas throughout the facility. Residents were observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)
Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)
Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

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

Attainment and Risk: FA

Evidence:

The chemicals are labelled and stored safely within the cleaning and laundry areas. The chemical safety data sheets are available throughout the facility. There are appropriate facilities for the disposal of soiled water/waste - i.e. sluice room; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Residents and family interviewed state they are satisfied with the cleaning and laundry service.

Two laundry staff members interviewed confirm that staff have been trained in chemical safety, infection control and waste management. Chemical safety and waste management training occurred in June 2014.

All laundry is done on site and the laundry has commercial washing machines and driers and there is a clean and dirty flow. There is appropriate protective equipment/clothing for staff and this was observed to be used. Cleaning and laundry audits are conducted by the facility and monthly monitoring of laundry processes is conducted by the external supplier of chemicals.

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:

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. All shifts have a trained first-aider. The New Zealand Fire Service approved the fire evacuation scheme on the 2 April 2014. Fire evacuation drills have occurred six monthly - last conducted on 10 June 2014 when a smoke alarm was activated. Each area of the service has emergency management flip charts to direct staff in the event of emergencies. Civil defence emergency supplies are maintained and checked regularly and is easily accessible to staff in an emergency. There is sufficient water stored and accessible in case of emergency. The facility has a large generator which can operate lighting and the kitchen. There is also battery operated emergency lighting, extra torches, and gas cooking. Fire alarms, smoke detectors and hose reels are checked by a contracted company. Testing and tagging of electrical appliances is due in November 2014. All equipment and appliances were purchased new with the opening of the facility. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms. The call bell system includes lights over the resident rooms and bathrooms and a lit panel in each corridor to identify in which room the assistance is required. Call bells were noted to be answered promptly. A further system is in use whereby a resident is given a wrist call bell when seated in the lounge area – especially for residents with higher care needs who are unable to mobilise. Security policies and procedures are in place. Advised by the village manager that all external doors are automatically locked on a timer and staff also check that the facility is secure. A recent incident in the town meant that the facility had to go in to 'lock down' during the day.

The electronic door locking system was overridden to ensure that all external doors were locked and secure. Electronic swipe cards are used to access the nurse's station and medication room.

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:

The service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

Residents (10 rest home and four hospital) and family (two rest home and two hospital) interviewed confirm the facilities are maintained at an appropriate temperature.

The maintenance person states all residents' rooms and communal areas heating can be individually adjusted. There is underfloor heating in residents' rooms, heat pumps and gas fires in the lounges. Sighted monthly air temperature audits.

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:

TerraceView has policies and procedures on restraint minimisation and safe practice. The senior registered nurse is the restraint coordinator at TerraceView.
Policy states that enablers are voluntary. There is one rest home resident using an enabler (bedrails) and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.
Documentation includes a restraint register, restraint/enabler assessment forms, restraint/enabler consent forms, an enabler plan in the resident care plan, monitoring forms, and three-monthly evaluation forms. Restraint education was provided for staff in November 2013 as part of the three day orientation and training programme.

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.)*

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The role of the infection control (IC) coordinator is held by a registered nurse with a graduate diploma in infection control. The IC coordinator has also attended outbreak management training in May 2014. The IC coordinator can access external specialist advice from GP's, laboratories and Bug control IC specialists when required. The IC programme is appropriate for the size and complexity of the service. The IC committee is part of the quality management team and includes representatives from all areas of the service. The IC coordinator reports to the village manager who reports to the board of directors. Infection is an agenda item at two monthly quality meetings with infection control objectives set for 2013 -2014. The service subscribes to Bug Control. The programme has been approved and reviewed annually by the IC coordinator and senior management team and external expertise when required. IC is a standing agenda item at the two monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IC coordinator and entered into the infection register. There is a job description for the IC coordinator including the role and responsibilities of the position. Staff and residents are encouraged to have the flu vaccine.

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:

A registered nurse is the infection control (IC) coordinator. The IC committee is part of the quality management team and includes representatives from all areas of the service. The IC coordinator reports to the village manager who reports to the board. IC matters are taken to all staff and quality meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GP's specialist advice when required. The IC coordinator will have the responsibility for reviewing the IC programme with the village manager including review of the infection control objectives (not yet due). The IC coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete infection control education. Access to specialists from the DHB, laboratories and GP's is available for additional training support. The IC coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.

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:

TerraceView has infection control policies and an infection control manual which reflect current practise and have been purchased from an external provider. The IC programme defines roles and responsibilities of the IC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IC coordinator. The IC programme will be reviewed annually by the IC coordinator who can access external specialist advice to do this (not yet due). Infection control policies include standard and additional precautions, monitoring and surveillance, outbreak management, antimicrobial usage, prevention and management of infections.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The IC coordinator (registered nurse) has completed a graduate diploma in infection control and has attended education related to outbreak management in May 2014. Infection prevention and control education was provided as part of the three day training days for all new staff. All subsequent new staff receive infection control education at orientation including hand washing and preventative measures. Infection control education occurs as part of the in-service training schedule. The training folder records the

staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.

The IC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the two monthly staff and quality meetings (minutes viewed). The facility subscribes to Bug Control. The IC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. The IC coordinator reports to the village manager who reports to the board.

Internal audit of infection control is included in the annual programme and occurs two monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. Staff are informed about IC practises and reporting. They can contact the IC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. The role of the infection control (IC) coordinator is held by a registered nurse who has been in the role since employment prior to opening (November 2013). The IC coordinator has IC qualifications, and attends external updates. The IC coordinator can access external specialist advice from GP's, laboratories and DHB IC specialists when required. The service reports that there have been no infection outbreaks.

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.)*