

# Bucklands Beach Rest Home Limited

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Current Status: 18 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

Bucklands Beach can provide care for up to 20 residents with 19 residents at rest home level of care on the day of the audit. The owner/ manager is responsible for the overall management of the facility and has been in the role for 14 years. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating that staffing reflects resident acuity and bed occupancy.

Improvements are required to the following: training for the manager/owner, registered nurse available in the absence of the manager/owner, quality improvement programme, dating of documents, care planning, documentation of the activity programme and medication administration.

## Audit Summary as at 18 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 18 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.		Standards applicable to this service fully attained.
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### Organisational Management as at 18 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.
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### Continuum of Service Delivery as at 18 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 medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 18 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.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 18 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.
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## Infection Prevention and Control as at 18 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.
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## Audit Results as at 18 September 2014

### Consumer Rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents.

Evidence-based practice is evident, promoting and encouraging good practice.

A policy on open disclosure is in place. There is evidence that residents and family are kept informed.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

### Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. A manager/owner is responsible for the day-to-day operations. A required improvement has been identified around professional development for the manager.

Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A required improvement is identified around communicating quality data and results with staff.

A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. Education and training programmes meet contractual requirements.

There are adequate numbers of staff on duty to ensure residents are safe. A required improvement is around ensuring there is a minimum of registered nurses (RNs) on-call cover in the manager/owner's absence.

The residents' files are appropriate to the service type and demonstrate service integration. There is a required improvement around dating the residents' falls assessments.

### **Continuum of Service Delivery**

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by the owner/manager (registered nurse). There is an initial assessment and plan completed with a long term care plan documented.

The service has an integrated system of documentation. Progress notes are completed daily and reflect the care provided. The general practitioner (GP) admits new residents within timeframes. Activities provided by the service are appropriate to the needs of residents requiring rest home level care.

Medicines management system is implemented and staff are trained and competent to administer medication. A resident's individual food, fluids and nutritional needs are met with the resident's food likes and dislikes noted.

Improvements are required to the following: care planning including ensuring that care plans include all aspects of care, updating the plans as changes occur, review of plans; the activities programme, ensuring that freezer temperatures are within the correct range and medication administration.

### **Safe and Appropriate Environment**

The building has an approved fire evacuation plan. All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. CPR and first aid certificates for two night shift staff have expired and is a required improvement.

### **Restraint Minimisation and Safe Practice**

The restraint management policy and staff state that enablers should be voluntary and the least restrictive option. There are no residents that require enablers and restraint is not used in the service.

### **Infection Prevention and Control**

The infection control programme is appropriate to the size and scope of the service. The infection control nurse (assistant manager – enrolled nurse) accesses resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention and the staff meeting is used for review of infection control. The infection control in-service trainings are provided for all staff.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Bucklands Beach Rest Home Limited
<b>Certificate name:</b>	Bucklands Beach Rest Home Limited

<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
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<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Bucklands Beach Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 18 September 2014 <b>End date:</b> 18 September 2014

<b>Proposed changes to current services (if any):</b>	
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<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	19
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## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	6
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<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	6	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	14	Total audit hours off site	12	Total audit hours	26
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Number of residents interviewed	5	Number of staff interviewed	5	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	14	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

## Declaration

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

Dated Wednesday, 15 October 2014

## Executive Summary of Audit

### General Overview

Bucklands Beach can provide care for up to 20 residents with 19 residents at rest home level of care on the day of the audit. The owner/manager is responsible for the overall management of the facility and has been in the role for 14 years. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads and acuity with rosters indicating that staffing reflects resident acuity and bed occupancy.

Improvements are required to the following: training for the manager/owner, registered nurse available in the absence of the manager/owner, quality improvement programme, dating of documents, care planning, documentation of the activity programme, and medication administration.

### Outcome 1.1: Consumer Rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents.

Evidence-based practice is evident, promoting and encouraging good practice.

A policy on open disclosure is in place. There is evidence that residents and family are kept informed.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

### Outcome 1.2: Organisational Management

Services are planned, coordinated, and are appropriate to the needs of the residents. A manager/owner is responsible for the day-to-day operations. A required improvement has been identified around professional development for the manager.

Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A required improvement is identified around communicating quality data and results with staff.

A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.



Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. Education and training programmes meet contractual requirements.

There are adequate numbers of staff on duty to ensure residents are safe. A required improvement is around ensuring there is a minimum of RN on-call cover in the manager/owner's absence.

The residents' files are appropriate to the service type and demonstrate service integration. There is a required improvement around dating the residents' falls assessments.

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

The resident's entry in to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by the owner/manager (registered nurse). There is an initial assessment and plan completed with a long term care plan documented.

The service has an integrated system of documentation. Progress notes are completed daily and reflect the care provided. The general practitioner (GP) admits new residents within timeframes. Activities provided by the service are appropriate to the needs of residents requiring rest home level care.

Medicines management system is implemented and staff are trained and competent to administer medication. A resident's individual food, fluids and nutritional needs are met with the resident's food likes and dislikes noted.

Improvements are required to the following: care planning including ensuring that care plans include all aspects of care, updating the plans as changes occur, review of plans; the activities programme, to freezer temperatures and medication administration.

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

The building has an approved fire evacuation plan. All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. CPR and first aid certificates for two night shift staff have expired and is a required improvement.

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

The restraint management policy and staff state that enablers should be voluntary and the least restrictive option. There are no residents that require enablers and restraint is not used in the service.

### **Outcome 3: Infection Prevention and Control**

The infection control programme is appropriate to the size and scope of the service. The infection control nurse (assistant manager – enrolled nurse) accesses resources both within and outside the organisation. Staff are knowledgeable about infection control and prevention and the staff meeting is used for review of infection control. The infection control in-service trainings are provided for all staff.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	35	0	8	2	0	0
<b>Criteria</b>	0	82	0	8	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	5
<b>Criteria</b>	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 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	The owner/manager has attended four of the eight hours required as per the ARC contract relating to professional development activities associated with managing a rest home.	Ensure the manager/owner attends a minimum of eight hours annually of professional development relating to the management of a rest home.	180
HDS(C)S.2008	Standard 1.2.2: Service Management	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.	PA Low			
HDS(C)S.2008	Criterion 1.2.2.1	During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA Low	Policy states that the enrolled nurse will cover in the absence of the manager/owner and there is currently no registered nurse on	Ensure a registered nurse is available to cover for all clinical responsibilities in the absence of the manager/owner.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				call or on site if that occurs.		
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The manager/owner reports that monthly quality data and quality initiatives are regularly discussed in staff meetings, although the staff meeting minutes do not reflect this. Nor is there evidence of results being displayed in a visible location.	Ensure there is documented evidence of quality improvement data results being regularly communicated to staff.	180
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 1.2.9.1	Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	Residents' files are dated and timed although dates are inconsistently documented on the falls assessments. This is a required improvement.	Ensure residents' falls assessments include dates when they were completed.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Cultural and spiritual domains (and at times other domains) are not always captured in the care plan as issues are not identified during the assessment. It is difficult to identify how to support the person to attend/not attend cultural activities; spiritual activities etc when specific strategies are not documented.	Ensure that the care plan includes all aspects of care identified in the assessment tool	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Documentation of a weekly/monthly/annual programme is not completed.	Document a weekly/monthly/annual programme.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	The daily care plan is not reviewed six monthly.	Ensure that the daily care plan is reviewed six monthly.	60
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 Moderate	The daily care plan and the long term care plan is not updated as changes occur at all times. Examples in files reviewed include a lack of update in the plans for a resident referred to the mental health service for the older adult, a trail of hip protectors following a fall for one resident and swallowing issues for a third resident.	Ensure that the daily care plan and the long term care plan are updated as changes occur.	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level	PA Moderate	(i)At times there is evidence of transcribing of instructions around	(i)Ensure transcribing of instructions around	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		administration of medication. (ii) Two of the ten prescriptions are not signed by the general practitioner.	administration of medication ceases. (ii) Ensure that the prescription is signed by the general practitioner.	
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 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Freezer temperatures are within the range identified in the policy however these are documented as being between -12 degrees Celsius and -18 degrees Celsius.	Review the policy to ensure that freezer temperatures are within the range identified as best and evidence based practice.	90
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	Currently two of the three night staff have expired CPR/first aid certificates. This is a required improvement. The manager reports staff are scheduled to attend CPR/first aid training on 30 September 2014. Since the draft report, the manager advised that this has been completed.	Ensure there is a minimum of one person available at all times with a current first aid/CPR certificate.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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:**

Staff receive training on the Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the on-going education and training programme. Interviews with staff (two of two caregiver, and one assistant manager (enrolled nurse) confirm their understanding of the Code. The most recent in-service was provided on 3 September 2014. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

### 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:**

Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The manager/owner or the enrolled nurse discusses aspects of the Code with residents and their family on admission. An explanation of the Code, including the complaint's process is also contained in the resident admission agreement.

Discussions relating to the Code are held informally during the six-weekly residents' meetings. Five of five residents and six of six relatives interviewed report the residents' rights are being upheld by the service.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service ensures that the residents' right to privacy and dignity is recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. All rooms are single rooms. Discussions of a private nature are held in the resident's room. Two of two caregivers interviewed report they knock on bedroom doors prior to entering rooms, ensure doors and curtains are shut when cares are being given and do not hold personal discussions in public areas. All five residents and six relatives interviewed confirm the residents' privacy is respected.

Two caregivers interviewed report that they encourage the residents' independence by encouraging them to be as active as possible.

Guidelines on abuse and neglect are documented in policy.

There have been no reported instances of abuse or neglect at the facility. Staff receive mandatory education and training on abuse and neglect, which was last provided on 6 November 2013. Two of two caregivers interviewed are aware of the signs of abuse and neglect.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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



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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. Cultural values and beliefs are documented in the resident's care plan. There are no Maori residents living at the facility during the audit. Maori consultation is available through the Counties Manukau District Health Board. The assistant manager (enrolled nurse (EN) also identifies as Maori. Staff receive education on cultural awareness during their induction and as an in-service topic. The most recent Maori cultural education in-service took place on 30 July 2014. The two caregivers interviewed are aware of the importance of whanau in the delivery of care for Maori residents.

### **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 identifies each resident's personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. Beliefs and values are discussed and incorporated into the

care plan. Family are encouraged to be involved in the development of the resident's long-term care plan. Five of five residents and six of six family members interviewed confirm they are involved in developing a plan of care for their family member, which includes the identification of individual values and beliefs.

#### **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:**

All staff have a position description to describe their working boundaries in caring for the residents. A staff code of conduct, house rules and conflict of interest are clearly defined in the policies and procedures and are discussed during the induction process. Professional boundaries are also included in the staff performance appraisal process. Interviews with two of two caregivers confirm their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through monthly education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.

### 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:**

Evidence-based practice is evident, promoting and encouraging good practice in most cases (refer 1.3.13.1). Two general practitioners (GP's) share monthly rounds. Residents are reviewed by the GP every three months. The service receives support from Counties Manukau DHB (CMDHB) which includes an RN from the Mental Health Services for the Older Person who visits the facility weekly. A gerontology nurse specialist visits once every 4-6 weeks. Physiotherapy services are available on an as-needed basis. There is a regular in-service education and training programme for staff. A podiatrist is onsite every six weeks and a hairdresser is available every two weeks. The service has links with the local community and encourages their residents to remain independent. Five of five residents and six of six families interviewed expressed their satisfaction with the care delivered. The GP interviewed is also satisfied with the level of care that is being provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a resident support and communication policy.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Six of six relatives report that they are always informed when their family member’s health status changes.

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

A specific policy to guide staff on the process of full and frank open disclosure is available. Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin. The incident form includes space to document that family were informed of the event. Family were contacted in all ten incident forms reviewed. Discussions with six family confirm that they are kept informed following GP visits, if the status of their family member changes or of any adverse event. Five of five residents state that they are kept informed and engaged.

There is an interpreter policy and staff are able to access interpreting services if required. There are no residents currently requiring interpreting services.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Informed consent is monitored through quarterly resident satisfaction surveys. The resident is asked to respond to whether they are given an explanation and reason for their care, whether they can refuse treatment, whether they feel in control of their daily needs and whether they are given choices in regards to their care. Twenty-three responses received in 2014 reflect that informed consent is upheld by the service.

There are consent forms on all files reviewed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**



**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Information on Advocacy Services through the Health and Disability Commissioner's (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at reception. Interviews with residents and families confirm their understanding of the availability of advocacy services. Staff receive annual education and training on the role of advocacy services through Age Concern.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do so. Residents have access to various community services (e.g., church groups, retired services association, visits to the local café and dairy).

### 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:**

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

There is a complaints flowchart. The complaints procedure is provided to resident/relatives at entry and is also prominent in a poster format, displayed on the wall. There is a complaints register that is up to date and includes relevant information regarding any lodged complaints.

Discussions with five residents and six relatives confirm they are provided with information on complaints and complaints forms.

The complaints register was reviewed. No complaints have been lodged in 2014 (year to date). Two complaints were lodged in 2013, with one of these complaints lodged through CMDHB on 24 October 2013. An investigation of the complaint lodged through CMDHB included a site visit by the CMDHB Health Clinical Speciality Nurse for Health of Older People. Based on information gathered during this investigation, it was determine in writing by the portfolio manager that the complaint was unsubstantiated. During this one day audit, it was also confirmed that the complaint was unsubstantiated. The manager/owner reports that the complaint was lodged by a disgruntled employee.

The second complaint lodged in 2013 was well-documented and included an investigation, follow up letter and resolution.

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

Two of two caregivers are able to describe the complaints process.

### 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:** PA Low

**Evidence:**

The business vision, philosophy, and mission statement are documented in the business plan. The company statement is 'We are committed to providing quality care and service with an emphasis on maintaining a strong sense of dignity and independence for residents with varying physical and/or intellectual challenges. Ten goals are clearly defined for the service. Each goal includes an action plan, date when achieved and a proposed budget. The business plan is reviewed on an annual basis and is rewritten every two years.

The owner is a registered nurse (RN) who works on-site as the RN for the service. She has over twenty years of aged care experience and has owned this rest home for the past 14 years. Over the past year she has experienced high staff turnover which included losing her assistant manager (RN). This resulted in her attending only four hours of professional development relating to the management of the service. This is a required improvement. .

**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:** PA Low

**Evidence:**

The owner is a registered nurse (RN) with a current practising certificate who works on-site as the RN for the service. She has over twenty years of aged care experience and has owned this rest home for the past 14 years. Over the past year she has experienced high staff turnover which included losing her assistant manager (RN). This resulted in her attending only four hours of professional development relating to the management of the service. This is a required improvement.

**Finding:**

The owner/manager has attended four of the eight hours required as per the ARC contract relating to professional development activities associated with managing a rest home.

**Corrective Action:**

Ensure the manager/owner attends a minimum of eight hours annually of professional development relating to the management of a rest home.

**Timeframe (days):** 180 (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:** PA Low

**Evidence:**

The manager/owner has employed an enrolled nurse (EN) with a current practising certificate to share the work load and on-call duties with her. Policy states that the EN will also cover in her absence and is a required improvement. The manager/owner was unaware that an RN must fill the nursing role in her absence. She reports that she has developed a relationship over the years with a nearby rest home that will be able to provide nursing cover while she is away on leave.

### 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:** PA Low

**Evidence:**

The manager/owner has employed an enrolled nurse (EN) with a current practising certificate to share the work load and on-call duties with her. Policy states that the EN will also cover in her absence and is a required improvement. The manager/owner was unaware that an RN must fill the nursing role in her absence. She reports that she has developed a relationship over the years with a nearby rest home that will be able to provide nursing cover while she is away on leave.

**Finding:**

Policy states that the enrolled nurse will cover in the absence of the manager/owner and there is currently no registered nurse on call or on site if that occurs.

**Corrective Action:**

Ensure a registered nurse is available to cover for all clinical responsibilities in the absence of the manager/owner.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Bucklands Beach Rest Home has a quality and risk management programme in place. Interviews with the manager/owner, one EN, two caregivers, one cook, an activities coordinator and a review of meeting minutes demonstrates their understanding of the quality and risk management system.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies are currently reviewed annually by the manager/owner with staff informed of any changes through the two-monthly staff meetings. A document control sheet at the front of each policy and procedure manual provides evidence of policies that have been reviewed and policies that have been either added or updated. The manager/owner is responsible for document control.

There is monthly accident/incident collation of data and monthly surveillance of infection reports. An internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented where opportunities for improvements are identified. Quality initiatives over the past year have included (but are not limited to) reducing falls through greater resident awareness when they are at risk of falling, 95% compliance with the number of residents who are at risk of falling wearing hip protectors, the development of an acuity system to ensure there is adequate staffing available and that residents are transferred to a hospital-level of care when indicated, the replacement of furnishings (higher beds and new dressing tables) and implementing a more effective resuscitation status system for the residents. The manager/owner reports that monthly quality data and quality initiatives are regularly discussed in staff meetings although the staff meeting minutes do not reflect this. This is a required improvement.

A risk management plan is in place that was last reviewed in April 2013. The service has a health and safety system in place. A health and safety officer is identified for the service. Health and safety audits take place each quarter. Hazard identification forms and a hazard register 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:** PA Low

**Evidence:**

There is monthly accident/incident collation of data and monthly surveillance of infection reports. An internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality initiatives over the past year have included (but are not limited to) reducing falls through greater resident awareness when they are at risk of falling, 95% compliance with the number of residents who are at risk of falling wearing hip protectors, the development of an acuity system to ensure there is adequate staffing available and that residents are transferred to a hospital-level of care when indicated, the replacement of furnishings (higher beds and new dressing tables) and implementing a more effective resuscitation status system for the residents. The manager/owner reports that monthly quality data and quality initiatives are regularly discussed in staff meetings although the staff meeting minutes do not reflect this. This is a required improvement.

**Finding:**

The manager/owner reports that monthly quality data and quality initiatives are regularly discussed in staff meetings, although the staff meeting minutes do not reflect this. Nor is there evidence of results being displayed in a visible location.

**Corrective Action:**

Ensure there is documented evidence of quality improvement data results being regularly communicated to staff.

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

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

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

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

The service collects incident and accident data. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the service's quality and risk management programme. Ten incident forms were reviewed across the service and all demonstrated follow up by the manager/owner, registered nurse (RN) or assistant manager, enrolled nurse (EN) to reflect clinical checks for the resident having been undertaken when indicated.

The manager/owner is aware of her statutory reporting obligations. There have been no serious events that have been required to be reported to specific authorities.

### 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:**

Annual practising certificates were sighted for the manager/owner (RN), and assistant manager (EN and GPs).

Five staff files were randomly selected for review (four caregivers, one enrolled nurse). There are recruitment policies in place including referee and police checks. Copies of interviews are kept on file. There is evidence of signed employment agreements in all five staff files. Signed job descriptions were evident in four of the five staff files with the manager/owner reporting that the EN's job description is at her home office. The EN confirms that she signed a job description as part of the employment process. All staff underwent a comprehensive orientation programme that included observations and sign-off by a senior staff member when competency is achieved. Completed orientation checklists were sighted in five of five staff files.

D17.7d: There are implemented competencies for staff that include medication, infection control and code of rights.

A senior caregiver is identified as the education facilitator and she facilitates workshops and ensures that content and attendance records are retained. Over eight hours of education are provided for staff each year.

Five of five residents and six of six relatives state that staff are knowledgeable.

### **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:**

There is a staffing policy that aligns with contractual requirements and includes skill mixes. The owner is a registered nurse who is on site 40 hours a week. She is assisted by an assistant manager (EN) who is onsite 32 hours per week. There are two caregivers on the AM shift (7am-2pm and 7am-9am), two caregivers on the PM shift (3pm-11pm and 4.45-7pm) and one caregiver on duty overnight (rosters sighted). No showering of residents occurs after 7pm where only one caregiver is available.

Staff are replaced if on leave as sighted on the day of the audit. Resident acuity is linked to the number of staff available.

Residents (five of five) and relatives (six of six) report staff are available to meet their needs.

### **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:**

The residents' files are appropriate to the service type. Residents entering the service have the relevant initial information recorded within 24 hours of entry into the service. Policies are in place relating to patient information. These policies are linked to the Health Information Privacy Code 1994 and the Privacy Act 1993. Individual residents' files demonstrate service integration.

All five residents' files sighted are sufficiently detailed. Residents' files are dated and timed although dates are inconsistently documented on the falls assessments. This is a required improvement. The name and designation of staff is noted for entries in the records sampled.

Current and archived records are stored securely. The records can only be removed by authorised personal.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.

### 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:** PA Low

**Evidence:**

All five residents' files sighted are sufficiently detailed. Residents' files are dated and timed although dates are inconsistently documented in the falls assessments. This is a required improvement.

**Finding:**

Residents' files are dated and timed although dates are inconsistently documented on the falls assessments. This is a required improvement.

**Corrective Action:**

Ensure residents' falls assessments include dates when they were completed.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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



## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Facilitation of resident entry in to the services is completed in a competent, equitable, timely, and respectful manner, when their need for services has been identified. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by the owner/manager (registered nurse). Annual practising certificates are sighted for the owner manager.

Five of five resident files confirm that owner/manager (registered nurse) conducts the initial assessment and develop the initial care plan.

The five residents and four relatives interviewed state that they receive information packs and sufficient information are provided to them prior to and on entry to the service. The information pack include what the service provides, the code of rights, complaints process and advocacy services. The owner/manager (registered nurse) reports that need assessments are required prior entry to the facility and these are on file in all files reviewed.

The admission agreement aligns with the ARC contract. The five of five reviewed resident files have signed admission agreements. Four of the files are for residents who have entered the service in 2013-2014 and all are signed on the day of admission (three of the four) or in the first week of admission (one of four). The fifth file is for a resident who entered the service in 2011. The admission agreement was signed in 2012 however the owner/manager (registered nurse) is aware of the need to have these signed on the day of admission.

The admission agreement aligns with the requirements for ARRC Clause 5.1 and "private payers" (two agreements reviewed) who have been needs assessed are not charged for services which are covered by the ARRC Agreement. This includes no payments for GP visits (D16.5), transportation to services (D20), supplies such as pharmaceuticals, wound dressing and continence supplies (D18). The admission assessment reflects that the "private payers" are not charged for services under the ARRC agreement with the same agreement used for private or subsidized residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The facility has an enquiry folder that keeps both walk in and telephone enquiries. The owner/manager (registered nurse) keeps the enquiry folder in the reception area. There is a section in the enquiry form which records the reason for declining entry to the service noting that there are few declined entry as these are managed through the needs assessment service.

The owner/manager notes that in the event that they cannot accept the resident due to a different level of care requirement, they refer the resident to the needs assessment service.

A policy on declining entry to the service is sighted – reviewed last in October 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals as confirmed by six family and five residents interviewed. There is a policy and process that describes resident admission and assessment procedures. The owner/manager (registered nurse) completes the assessment on admission using standardised tools.

The front page includes brief mention of medical history, medications (name only), allergies, social history (brief), religious beliefs, cultural beliefs, reason for admission, hobbies, special friends, diet, resuscitation status, baseline recordings, valuables on admission and if a funeral has been arranged. All residents have an enduring power of attorney on file and informed consent and resuscitation documentation completed on entry. There is an admittance checklist completed.

There is a comprehensive nursing assessment completed on five of five files reviewed. This is completed on the day of entry along with the initial daily care plan with documentation of a care plan for any specific issues relevant to the resident. There is a daily care plan that gives strategies and care requirements for activities of daily living and a long term care plan which picks out any specific needs of the resident over and above daily care needs.

Medical assessments are completed within 24-48 hours of admission by the general practitioner (GP) in all five reviewed resident files. The GP examines the residents three monthly with this stamped on the medical notes at each visit. The general practitioner confirms that they would see the resident more frequently depending on the resident level of needs and this is documented in the medical notes.

There is a verbal hand-over between shifts as sighted during the day of the audit. The contents of the hand-over ensures continuity of care. Residents on antibiotics, hospital appointments, required procedures and other vital information's are handed over to the next shift.

Short-term care plans are sighted as required in resident files. Resolution of the acute condition is documented in the care plan. Progress notes are maintained and documented at least daily. All five of five reviewed resident's files identify integration of notes including allied professionals e.g. general practitioner, caregivers and others. Hospital discharge letters and specialist letters and referrals are sighted in the resident's files.

Tracer Methodology 1- Rest home level of care

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The owner/manager (registered nurse) completes a nursing initial assessment on admission using standardised tools. The initial risk assessment tools and ongoing assessments include falls, pressure areas, cognition, mobility, mental health, dietary, continence, pain, cultural/spiritual (self-identity) and recreation. Baseline vital signs and weights are taken on admission and recorded. The data collected during the assessment are utilised to develop the initial plan of care for the resident with the involvement of the resident and/or family. The information gathered by the owner/manager serves as the basis for the care plans of the residents.

The owner/manager ensures that the new resident and their family if involved are orientated to the facility including meal times, how to reach staff, complaints process and other relevant information which they require to settle in their new home.

The general practitioner (GP) admits the new resident within 24-48 hours and completes a medical assessment as sighted in all five reviewed files.

Five of five resident files include a documented nursing assessment.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The initial assessment and plan documented on the day of admission by the owner/manager forms the basis for the care plans developed within three weeks of admission (the daily care plan and the long term care plan are all sighted as being developed within 48 hours in the five files reviewed). Plans are developed with the resident and/or with their families. Resident needs, goals, objectives and interventions are identified, agreed and care to be delivered is explained with the resident when able as well as with the resident's family. The five care plans reviewed all include a daily care plan around activities of daily living e.g. showering, toileting, mobility etc with long term care plans identifying any areas where there are individual and specific resident needs e.g. diabetes, orientation of a resident who has Alzheimer's etc.

Short term care plans are developed when residents have infections, skin tear etc as sighted in five of five files reviewed. The plans are specific and resident-focused.

The service delivery plans demonstrate integration of notes.

An improvement is required to the care plan to ensure that all aspects of the resident's needs are included.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The care plan is documented using an exception approach i.e. if the assessment states that the resident is not requiring support in a particular area, then the care plan does not reflect any documentation. There is always a daily care plan to guide staff around resident needs for activities of daily living and a long term plan with specific issues identified and strategies documented.

**Finding:**

Cultural and spiritual domains (and at times other domains) are not always captured in the care plan as issues are not identified during the assessment. It is difficult to identify how to support the person to attend/not attend cultural activities; spiritual activities etc when specific strategies are not documented.

**Corrective Action:**

Ensure that the care plan includes all aspects of care identified in the assessment tool

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service provides rest home level of care. There is one resident using respite services on the day of the audit. Individualised and resident-focused plans are developed with any issues identified in the long term care plan. When the long term care plan is documented, there are strategies are sighted to address the desired outcome/goal of the resident.

The facility has sufficient equipment that includes continence products, wheelchairs and handling belts to transfer or to assist residents to mobilise. There is an adequate supply of dressings, continence products and linen for residents for staff to use as sighted on the day of the audit.

The general practitioner states that the service is responsive to any concerns and contacts medical services appropriately. A referral to the hospital for a resident following a fall immediately after the fall indicates that the service responds to signs and symptoms appropriately.

The five residents interviewed state that their needs are being met and they are receiving appropriate clinical, medical and personal care. The six relatives interviewed confirm the resident's statements and verbalised that they are very satisfied with the care provided by the service. All state that care and support is excellent with staff going out of their way to provide individual care to meet needs.

### 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:** PA Low

**Evidence:**

The activities for the residents are planned by the activities coordinator who has been in the role for two years. The programme includes activities that are physical, intellectual, spiritual, sensory, social and fun. There are group activities for crafts, paintings and drawings. Entertainers visit the facility. The service takes the residents for bus trips, outings, cafes, library visits and shopping as per individual needs with family actively engaged in the service.

The activities coordinator develops the activities plan using the assessment documented during admission. The owner/manager reviews the individual goals for each resident in conjunction with review of the care plan. The activities coordinator records attendance for 14 of the 19 residents.

The daily/weekly programme is put on the whiteboard in the lounge for residents and family to see and there is evidence of actively motivating residents to engage in activities. A permanent record of the programme is not planned and documented.

Five residents interviewed state that the activities provided for them by the activities coordinator are enjoyable, stimulating and tailored to their needs as well as for the group. Residents participate in their preferred activities.

Improvements are required to documentation of the weekly/monthly/annual activities programme.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The daily/weekly programme is put on the whiteboard in the lounge for residents and family to see.

The activities coordinator records attendance for 14 of the 19 residents.

**Finding:**

Documentation of a weekly/monthly/annual programme is not completed.



**Corrective Action:**

Document a weekly/monthly/annual programme.

**Timeframe (days):** 180 (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 Moderate

**Evidence:**

The five care plans are expected to be evaluated six monthly and updated as changes occur as per policy. Short term care plans are evaluated and resolutions of the problems are documented in the short term care plans and in the resident's progress notes. There is a documented three monthly GP review or as required depending on the complexity and level of care of the resident.

The long term care plan is reviewed six monthly. The daily care plan around activities of daily living is documented initially and at times reviewed as sighted in two files.

Improvements are required to review of the daily care plan and to updating of the care plan as changes occur.

**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:** PA Moderate

**Evidence:**

The long term care plan is reviewed six monthly. The daily care plan around activities of daily living is documented initially and at times reviewed as sighted in two files.

**Finding:**

The daily care plan is not reviewed six monthly.

**Corrective Action:**

Ensure that the daily care plan is reviewed six monthly.

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

**Evidence:**

At times, the daily care plan and the long term care plan is updated as changes occur.

**Finding:**

The daily care plan and the long term care plan is not updated as changes occur at all times. Examples in files reviewed include a lack of update in the plans for a resident referred to the mental health service for the older adult, a trail of hip protectors following a fall for one resident and swallowing issues for a third resident.

**Corrective Action:**

Ensure that the daily care plan and the long term care plan are updated as changes occur.

**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 owner/manager (registered nurse) facilitates resident access to other medical and non-medical services available for them. The owner/manager confirms initiating referrals for continence, wounds, disability support for change in level of care, mental health/psychiatric services, podiatry and dietician as required. The GP initiates specialist referrals as sighted in the medical notes. The change in the resident's level of care is initiated by the owner/manager as required. The general practitioner confirms that there are no residents currently in the service who require a change in the level of care. The families are informed by the owner/manager when reassessments are completed as well as the outcomes as confirmed by the family members interviewed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There is a policy that describes guidelines for transition, exit, discharge or transfer from services. The owner/manager reports that there are processes implemented to transfer residents to the public hospital and to receive residents back from the public hospital. Hospital discharge notes and plans are received on discharge from the hospital and kept in the resident file.

The owner/manager confirms that risks are identified prior to a transfer or discharge of a resident. There is an open communication between the service, the GP, the resident and families as confirmed by the general practitioner, family and residents interviewed.

### **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:** PA Moderate

**Evidence:**

Medicines for residents are received from the pharmacy in a packed medicine delivery system (robo packs). The medicines are checked for accuracy against the resident's medication charts. Medicines are stored in locked medicine cupboard. The staff administering the lunch time medications in the rest home are following the medication administration procedure as sighted on the day of audit.

There are no residents requiring controlled drugs, however there is a system and process documented with this described by the assistant manager. Any expired medications are returned to pharmacy. There are no expired medicines sighted in the medication room.

Eight out of ten prescriptions are signed by the GP. All prescriptions sighted contain the date, medicine name, dose and time of administration. All allergies are documented in the 10 out of 10 medication charts.

There is a photo of each resident to support administration of medication.

The assistant manager states that medications are not crushed. Eye drops are dated on the day of starting them.

There are processes in place for self-administration however residents only keep some local creams in their room so that these can be used at shower time.

The medication competencies for all staff are current and staff have training around administration of medication annually.

There is PRN medication documented and staff at times document this correctly.

Improvements are required to transcribing and signing of the prescription by the general practitioner.

### 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:** PA Moderate

**Evidence:**

There is PRN medication documented and staff at times document this correctly. Eight out of ten prescriptions are signed by the GP.

**Finding:**

(i) At times there is evidence of transcribing of instructions around administration of medication. (ii) Two of the ten prescriptions are not signed by the general practitioner.

**Corrective Action:**

(i) Ensure transcribing of instructions around administration of medication ceases. (ii) Ensure that the prescription is signed by the general practitioner.

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

A resident's individual food, fluids and nutritional needs are met where this service is a component of service delivery. The food service manual is sighted. The owner/manager admits new residents to the facility and completes a dietary requirement form, with any likes/dislikes/allergies documented on the white board behind the door in the kitchen. The cook reports that they cook special meals if required.

The food handling certificate for the cook is displayed in the kitchen. The five week rotating menu is reviewed by the dietician last in April 2014. The served meals are suitable for aged care residents and the food presented during the audit is as per the current menu. Food temperatures are conducted weekly with fridge temperatures within range. Freezer temperatures are within the range identified in the policy however these are documented as being between -12 degrees Celsius and -18 degrees Celsius. Food checked in the freezer on the day of the audit is frozen. The fridges are clean and with intact rubber seals. The cook reports that the cooked meat temperatures are recorded immediately after the food is removed from the oven and the temperatures recorded are within normal range. Meals are well presented and are tasty and hot on the day of the audit. An improvement is required to freezer temperatures.

Staff are using clean technique in food preparation. The cook rotates canned goods and labels all cooked and opened foods in the fridge. The kitchen is clean and there are adequate food supplies in the pantry. The cook places order directly to the supplier and checks quantity and quality of delivered items.

The monthly weight monitoring is evidence in five of five reviewed resident files and the weights are stable. There is one resident taking fortisip and another having sustagen.

**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:** PA Low

**Evidence:**

Food temperatures are conducted weekly with fridge temperatures within range. Food checked in the freezer on the day of the audit is frozen.

**Finding:**

Freezer temperatures are within the range identified in the policy however these are documented as being between -12 degrees Celsius and -18 degrees Celsius.

**Corrective Action:**

Review the policy to ensure that freezer temperatures are within the range identified as best and evidence based practice.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staffs receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas.

Visual inspection of the facilities provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

Staff have last received training around chemicals as part of the infection control training in August 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:**

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 8 June 2015). There have been no buildings modifications since the last audit and any maintenance issues are addressed as they arise.

The lounge area is designed so that space and seating arrangements provides for individual and group activities with the activity programme offered in the lounge on the day of the audit.

There is a test and tag programmes two yearly and this is up to date having been completed in 2014. BV Medical have checked all medical equipment in 2014.

Interviews with two caregivers and the owner/manager confirm there is adequate equipment and cupboards viewed indicate that there are plenty of supplies.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required. There are safe outside areas that are easy to access for residents and family members.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/bathing facilities. This includes shared ensuites in some rooms and communal toilets conveniently located close to communal areas.

Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Five residents and six family members 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 adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this noting that hoists are not required.

Rooms can be personalized with furnishings, photos and other personal adornments.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required and mobility scooters are stored in a covered area.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The service has a lounge and dining area which is large with appropriate floor coverings. All areas are easily accessed by residents and staff. 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:**

Laundry is completed on site by caregivers and linen is stocked in hall cupboards. The cleaning is completed by caregivers with products stored in a locked room. Cleaning is monitored by the owner/manager. Chemicals and cleaning cupboards are locked on the day of the audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Emergency and disaster policies and procedures are in place. The New Zealand Fire Service approved the fire evacuation plan on 2 Sept 1999. A fire drill takes place six-monthly with the most recent drill occurring 18 March 2014. The orientation programme includes fire and security training. Staff interviews confirm their understanding of emergency procedures.

Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. A back up three- hour battery for emergency lighting is in place.

A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.

Currently two of the three night staff have expired CPR/first aid certificates. This is a required improvement. The manager reports staff are scheduled to attend CPR/first aid training on 30 September 2014.

External lighting is adequate for safety and security.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Emergency and disaster policies and procedures are in place. The New Zealand Fire Service approved the fire evacuation plan on 2 Sept 1999. A fire drill takes place six-monthly with the most recent drill occurring 18 March 2014. The orientation programme includes fire and security training. Staff interviews confirm their understanding of emergency procedures.

Currently two of the three caregiver staff who work the night shift have expired CPR/first aid certificates. This is a required improvement. The manager reports staff are scheduled to attend CPR/first aid training on 30 September 2014.

**Finding:**

Currently two of the three night staff have expired CPR/first aid certificates. This is a required improvement. The manager reports staff are scheduled to attend CPR/first aid training on 30 September 2014. Since the draft report, the manager advised that this has been completed.

**Corrective Action:**

Ensure there is a minimum of one person available at all times with a current first aid/CPR certificate.

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

**Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**



**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There are procedures to ensure 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. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

### **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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint management policy and staff state that enablers should be voluntary and the least restrictive option. There are no residents that require enablers and restraint is not used in the service.

Training around restraint minimisation and enablers is linked to the annual in-service on managing challenging behaviours. This in-service was most recently provided by the CMDHB mental health team on 2 October 2013.

#### **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

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### **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:**

There are clear lines of accountability for infection control and prevention for the service. Infection control and prevention is integrated into the monthly meetings. The infection control programme is appropriate to the size and scope of the service. The assistant manager (enrolled nurse) is the designated infection control nurse (ICN). The job description of the infection control nurse is signed as evidence in the staff file and in the infection control folder.

The two caregivers, the owner/manager and the assistant manager are able to demonstrate good knowledge on preventing the spread of infection, breaking the chain of infection and confirmed knowledge of hand washing. They state that they will take a sick leave when not able to attend their shift and describe when to inform management regarding signs/symptoms of an outbreak of infectious disease.

Visitors, families and staff are reminded not to enter the service when not feeling well. A hand sanitizer is sighted in the reception area.

The policies are reviewed two yearly..

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The assistant manager (enrolled nurse) is the designated infection control nurse (ICN) who has access to the GP, laboratory and microbiologist. The owner/manager provides assistance to the assistant manager. The ICN has access to the general practitioner for advice and support as confirmed by the general practitioner interviewed and to the Counties Manukau District Health Board infection control nurse specialist and to district nurses.

There are infection control signs within the service to prevent the spread of infections. Handgels are available and sufficiently distributed inside the facility.

The infection control nurse has access to relevant and current information including internet and the Ministry of Health web pages.

#### **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:**

The service has documented policies and procedures implemented for the prevention and control of infection that reflects good practice that meets relevant legislative requirements. These policies and procedures are practical, safe, and appropriate for the type of service provided.

The two caregivers interviewed confirm that the policies and procedures are accessible to them when they need to read about certain topics. Infection control prevention and control is integrated in the orientation programme for all staff. The caregivers also state that the infection control nurse is available to them to clarify infection control issues or some procedural concerns regarding infection control.

#### 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 service provides relevant education on infection control prevention and control to all staff and residents. This is evident in the monthly meetings with the last training provided to staff in August 2014 (all completed a competency). All staff interviewed articulate knowledge of the infection control and prevention programme as per policy.

The ICN has completed infection control training at a previous facility and is booked into Bug Control training in November 2014.

**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:**

There is an infection control surveillance-data gathering and review policy in place, which outlines the purpose and methodology for the surveillance of infections. Infection control data is collated monthly and includes surveillance analysis of multi-resistant organisms associated with anti-microbial use. Surveillance data and analysis is sighted. Two caregivers, the enrolled nurse and owner/manager confirm infection control is discussed at staff meetings and they are made aware of any resident infections at shift handovers. Definitions of infections and rates are in place appropriate to the complexity of service provided. Infections are documented on the individual infection control report form in each resident file. The infection control co-ordinator summarises the infections each month and provides a monthly report. Infections are also graphed monthly.

#### 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.)*