Marne Street Hospital Limited

Current Status: 24 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

Marne Street Hospital provides hospital, rest home and residential disability level care for up to 53 residents. On the day of the audit there were 45 hospital level residents and five residents with disabilities (physical and intellectual). The facility is privately owned. The facility manager is an experienced manager who has been in the role for 2.5 years. The service also employs a full time clinical manager and registered nurses 24/7. The clinical manager is experienced in aged care, with previous roles in management and aged care and has been employed for the past two years. The owner, facility manager, and clinical manager have a sound understanding of aged care. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided.

This audit also included assessing the service reconfiguration with the addition of two extra hospital rooms. The facility, staffing, activities programme and roster is appropriate for providing additional two hospital rooms.

Audit Summary as at 24 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 24 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.

Organisational Management as at 24 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.		Standards applicable to this service fully attained.

Continuum of Service Delivery as at 24 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.		Standards applicable to this service fully attained.

Safe and Appropriate Environment as at 24 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.

Restraint Minimisation and Safe Practice as at 24 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Infection Prevention and Control as at 24 September 2014

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

Audit Results as at 24 September 2014

Consumer Rights

The support provided to residents at Marne Street Hospital is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is sought and advanced directives are appropriately recorded. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

Organisational Management

Marne Street Hospital has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The facility manager is an experienced manager and is supported by the owners, a clinical manager and registered nursing staff. The facility is guided by a comprehensive set of policies and procedures. A quality coordinator and the facility manager are responsible for implementing the quality programme. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Continuum of Service Delivery

The registered nurses are responsible for each stage of service provision. The development of the nursing care plans, activity plans and evaluations are reviewed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. Three monthly multidisciplinary reviews involve the GP, allied health professionals and resident/family. The Diversional Therapist develops a monthly activities programme that meets the residents' needs and interests. Residents are supported to

maintain links with the community and volunteers assist with the activity programme. The facility has a car that can be used for outings, for those in wheel chairs the wheel chair taxi is utilised.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification allergies and special instructions for administration. Food services and all meals are provided by an external catering company. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus, all staff are trained in food safety and hygiene.

Safe and Appropriate Environment

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. There are large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines

Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are nine residents on restraints and ten residents using enablers. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the six monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation

Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and the registered nurse is the infection control coordinator. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator has attended infection prevention education. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Marne Street Hospital Limited
Certificate name:	Marne Street Hospital Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Certification Audit
Premises audited:	Marne Street Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	**Start date:** 24 September 2014 **End date:** 25 September 2014

Proposed changes to current services (if any):
The service is in the process of reconfiguration of services with the addition of two hospital rooms currently partially completed.

Total beds occupied across all premises included in the audit on the first day of the audit:	50

Audit Team

Lead Auditor	XXXXXXXX	**Hours on site**	11.5	**Hours off site**	6
Other Auditors	XXXXXXX	**Total hours on site**	11.5	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXX			**Hours**	2

Sample Totals

Total audit hours on site	23	Total audit hours off site	13	Total audit hours	36

Number of residents interviewed	10	Number of staff interviewed	14	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	8	Total number of managers (headcount)	2
Number of medication records reviewed	16	Total number of staff (headcount)	63	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			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	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 23 October 2014

Executive Summary of Audit

General Overview

Marne Street Hospital provides hospital, rest home and residential disability level care for up to 53 residents. On the day of the audit there were 45 hospital level residents and five residents with disabilities (physical and intellectual). The facility is privately owned with one owner providing accounting. The facility manager is an experienced manager who has been in the role for 2.5 years. The service also employs full time clinical manager and registered nurses 24/7. The clinical manager is experienced in aged care, with previous roles in management and aged care and has been employed for the past two years. The owner, facility manager, and clinical manager have a sound understanding of aged care. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke positively about the care and support provided.

This audit also included assessing the services reconfiguration of services with the addition of two extra hospital rooms. The facility, staffing, activities programme and roster is appropriate for providing additional two hospital rooms.

Outcome 1.1: Consumer Rights

The support provided to residents at Marne Street Hospital is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents receive a high standard of support and assistance. Residents report that they feel safe. There is no evidence of harassment or discrimination. Staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Appropriate policies, procedures and links to the community are in place to ensure culturally appropriate support is provided. Residents are encouraged to maintain links with their family/whanau and friends and to attend activities involving the local community. Informed consent is sought and advanced directives are appropriately recorded. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

Outcome 1.2: Organisational Management

Marne Street Hospital has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The facility manager is an experienced manager and is supported by the owners, a clinical manager and registered nursing staff. The facility is guided by a comprehensive set of policies and procedures. A quality coordinator and the facility manager are responsible for implementing the quality programme. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Outcome 1.3: Continuum of Service Delivery

The registered nurses are responsible for each stage of service provision. The development of the nursing care plans, activity plans and evaluations are reviewed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. Three monthly multidisciplinary reviews involve the GP, allied health professionals and resident/family. The Diversional Therapist develops a monthly activities programme that meets the residents' needs and interests. Residents are supported to maintain links with the community and volunteers assist with the activity programme. The facility has a car that can be used for outings, for those in wheel chairs the wheel chair taxi is utilised.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification allergies and special instructions for administration. Food services and all meals are provided by an external catering company. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus, all staff are trained in food safety and hygiene.

Outcome 1.4: Safe and Appropriate Environment

The service has implemented policies and procedures for fire, civil defence and other emergencies. There are staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms are individualised. External areas are safe and well maintained. There are large spacious lounges and dining areas. There are adequate toilets and showers. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored securely. Appropriate policies are available along with product safety charts. The temperature of the facility is comfortable and constant and able to be adjusted in resident's rooms to suit individual resident preference. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are nine residents on restraints and ten residents using enablers. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the six monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation

Outcome 3: Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and the registered nurse is the infection control coordinator. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs

of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The infection control coordinator has attended infection prevention education. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	On the day of the audit the two rooms were partially completed.	Ensure that prior to occupancy a code of compliance is completed and the rooms are fully equipped with call bell, heating, lighting, toilet/shower and furniture.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six caregivers, one diversional therapist, four registered nurses, clinical manager, and facility manager) confirm their familiarity with the Code. Interviews with 10 residents (nine hospital and one YPD) and seven relatives (six hospital and one young person with disabilities (YPD)) confirm the services being provided are in line with the Code of rights.
Code of rights and advocacy training is provided during new staff orientation, as part of ACE care giver training, and as a regular in-service education and training topic (last provided in March 2014 with 27 attendees).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with 10 residents and seven relatives identify they are well-informed about the code of rights. The service provides an open-door policy for concerns or complaints.
Two monthly resident/relative meetings (minutes sighted for August 2014)) are held providing the opportunity to raise concerns in a group setting. The most recent annual satisfaction survey (November 2013) includes the question relating to privacy, dignity and rights with 100% of the respondents replying they are either satisfied or very satisfied.
Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.
D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner Information.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies align with the requirements of the Privacy Act and Health Information Privacy Code - including: confidentiality, privacy and dignity. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.
Discussions with 10 residents and seven relatives confirm personal belongings are not used as communal property. Property is recorded on admission with direction from the resident and family.
D3.1b, d, f, i the service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.
D14.4 there are clear written instructions provided to residents and family on entry regarding responsibilities of personal belongings. Personal belongings are documented and included in residents' files.
Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. All 10 residents and seven relatives confirm the service is respectful.
A resident satisfaction survey is carried out annually to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents and families are 100% satisfied or very satisfied.
D4.1a: Residents' files include their cultural and /or spiritual values when identified by the resident and/or family.
The information pack, provided to residents and their families, includes the home's philosophy of care. Discussions with 10 residents confirm that residents are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Eight care plans (seven hospital and one intellectual/physical disability) reviewed identify specific individual likes and dislikes. There are no married couples currently residing at Marne Street Hospital.
The abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and

training on abuse and neglect is a mandatory requirement and last provided in May 2014 with 26 attendees.
Discussions with the facility manager and clinical manager report there have been no identified incidents of abuse or 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:

There is a cultural safety policy. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.
There is one resident (hospital level) living at the facility at the time of the audit. The resident's long term care plan identifies cultural needs and advised by staff that the resident is provided with food in line with his cultural preferences when he requests this. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori healthcare providers.
D20.1: The service utilises a local Maori representatives on an as-needed basis for consultation. These contacts are identified in policy.
Interviews with six caregivers and four registered nurses confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau.
A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Care planning includes consideration of spiritual, psychological and social needs. Ten residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Seven relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions.
D3.1g: The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the clinical manager and registered nurses
D4.1c: Eight of eight care plans reviewed include the residents' social, spiritual, cultural and recreational needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The staff induction programme includes a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the facility manager and one recently employed caregiver. Interviews with six caregivers, four registered nurses and the clinical manager acknowledge their understanding of professional boundaries. Registered nurses have attended professional boundaries and code of conduct external professional development sessions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. Resident satisfaction surveys reflect high levels of satisfaction with the services that

are received. The facility manager and the quality coordinator/enrolled nurse are in charge of the internal audit and in-service education programmes. There is access to computer and Internet resources. There are monthly RN/quality meetings, two monthly caregiver meetings and two monthly resident meetings.
Ten residents and seven relatives interviewed spoke very positively about the care and support provided. Six caregivers, four registered nurses, one diversional therapist, the clinical manager and the facility manager have a sound understanding of principles of aged care.
A2.2: Services are provided at Marne Street Hospital that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring.
D1.3: All approved service standards are adhered to.
D17.7c: There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies are in place relating to open disclosure. Ten residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.
A sample of incident reports reviewed, and associated resident files, evidence recording of family notification. Seven relatives interviewed confirm they are notified of any changes in their family member's health status. The facility manager, clinical manager and four registered nurses can identify the processes that are in place to support family being kept informed.

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 for that are not covered by the agreement.
The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.
D11.3 The information pack is available in large print and is read to sight-impaired residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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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:

Written informed consent is gained for do not resuscitate or resuscitation orders appropriately for eight of eight files sampled (six from the hospital and two YPD). Eight files were reviewed and found to have valid consents. It was stated by the registered nurse and clinical nurse manager that family involvement occurs with the consent of the resident. Other forms of written consent included consent to share information, consent for photographs and consent for transportation. A review of eight files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Ten residents interviewed (nine from the hospital and one YPD) confirm that they are given good information to be able to make informed choices. Six caregivers, four registered nurses, one enrolled nurse the clinical nurse manager interviewed conform information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.

D13.1 There were eight of eight admission agreements sighted.

D3.1.d Discussion with seven family (six from the hospital and one YPD) identified that the service actively involves them in decisions that affect their relative's lives.

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with six caregivers, four registered nurses and one enrolled nurse identify that consents are sought in the delivery of personal cares and this is confirmed by 10 residents interviewed (nine hospital and one YPD). Resuscitation policy is implemented and there are signed forms in all resident files reviewed. Resuscitation forms are reviewed annually.

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

D3.1.d: Discussion with seven family/whanau identified that the service actively involves them in decisions that affect their relative's lives.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception.
Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items.
D4.1e; The residents' files include information on residents family/whanau and chosen social networks.
Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.
D4.1d; Discussions with seven relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The client information pack informs visiting can occur at any reasonable time. Interviews with ten residents and seven relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.
D3.1.e Discussions with ten residents and seven relatives verify that they are supported and encouraged to remain involved in the community. Marne Street Hospital support on-going access to community services (e.g. church, general practitioner visits, and family outings). Entertainers are invited to perform at the facility.
D3.1h: Discussions with seven relatives verify that they are encouraged to be involved with the service and care.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Complaint forms are available at the reception area of the service.
Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service.
Interviews with ten residents and seven relatives are familiar with the complaints procedure and state any concerns or complaints are addressed.
The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved.
There have been 10 lodged complaints in 2014. Nine are closed following resolution and one recent complaint remains open. Evidence of a full investigation and resolution including communication with complainants is documented for each lodged complaint. Complaints are discussed at management meetings, RN/quality meetings and staff meetings.
D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Marne Street Hospital is certified to provide rest home, hospital level and disability services care for up to 53 residents, with 50 residents accommodated on the day of audit. The service has approval for 10 dual purpose beds (rest home or hospital) however, there were no rest home level residents accommodated on the days of audit. There are 45 hospital level residents and five residents with disabilities (physical and intellectual). There are clearly defined and measurable goals developed for the business plan and quality and risk management plan. The mission statement states that "in partnership – we are committed to providing the highest quality holistic care and services for our residents, which exceed their expectations". The vision and values include respect, caring and compassion, integrity, unity and discovery. The mission statement is included in the information booklet, which is given to each resident and family on admission.

An organisational chart visually describes reporting relationships for the ownership and management structure. The service has a business plan and a quality and risk management plan for 2014. The business plan includes goals relating to financial management, occupancy, staff retention and recruitment and building repairs and maintenance. The quality and risk management plan includes a focus on resident care, provision of effective programmes, meeting certification and contractual requirements, risk management and continuous improvement. Quality indicators are documented. Further specific quality initiatives includes improving work place effectiveness, specific infection prevent activities, continuation of care and effective communication between GP, RN and family, and monitoring and minimising incidents of falls. Dates for completion are documented with evidence of ongoing monitoring. The internal audit programme regularly assesses service performance.

The facility is privately owned with one owner providing accounting support. Advised by one owner that the owners meet monthly and a report from the facility manager is

discussed. The facility manager is an experienced manager who has been in the role for 2.5 years. The service also employs full time clinical manager and registered nurses 24/7. The clinical manager is experienced in aged care, with previous roles in management and aged care and has been employed for the past two years. The owners, facility manager, and clinical manager have a sound understanding of aged care. The facility manager has attended professional development in the past year relating to managing the facility including an aged care managers forum and attending two monthly provider meetings in Dunedin.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the facility manager's absence, the clinical manager is in charge. The facility manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the quality coordinator/enrolled nurse and the clinical manager. Formal management meetings are held three monthly between the facility manager, clinical manager and the quality coordinator with discussion around occupancy, business plan development and monitoring, resident issues, and staffing.
D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The quality and risk management system is understood and implemented by the facility manager, owners and staff.
A comprehensive set of policies and procedures are in place. The facility manager reports that new and/or revised policies are developed with input from staff. The facility manager signs off on all new policies. They are available for staff to read and to sign after reading.
Policies and procedures are stored in hard copy at the facility. Each policy includes a review date and lists related documents (if any). Policies are scheduled to be reviewed two-yearly unless changes occur more frequently. As a face sheet in each manual, and lists of policies and procedures that have been either recently developed or revised are documented.
Key components of service delivery are linked to the quality and risk management programmes. The service has a business plan and a current quality and risk management plan for 2014. The business plan includes goals relating to improving quality issues, occupancy, staff retention and recruitment, supporting residents and families, maintain the facility environment, health and safety, infection control and restraint. The quality and risk management plan includes a focus on resident care, provision of effective programmes, meeting certification and contractual requirements, risk management and continuous improvement. Each quality goal has documented processes and activities for achievement, with a corrective action format implemented for non-achievement of goals and objectives. Quality activities include internal audits, feedback from staff and residents, incidents and accidents and complaints. Further specific quality initiatives includes improving work place effectiveness, specific infection prevent activities, continuation of care and effective communication between GP, RN and family, and monitoring and minimising incidents of falls. Dates for completion are documented with evidence of on-going monitoring. The internal audit programme regularly assesses service performance. Quality improvements and corrective actions are recorded and followed through to completion.

The resident/relative survey conducted in November 2013 attracted 18 resident and five family respondents. Comments were very positive with residents and families stating they were over all very satisfied. Survey outcomes have been communicated to residents via a resident meeting and have been published in the facility newsletter. Discussions with individual residents also occurred to address any issues that were identified via the survey process. Residents/families were surveyed around privacy and dignity, open disclosure, medical services, assistance from care staff, cleaning, food services, activities, laundry, safety and security, and gardening. Formal management meetings are held three monthly (minutes sighted for August 2014), monthly meetings are held which combine registered nurses, quality, restraint, and infection control (minutes sighted for September 2014). Care staff meetings are held two monthly (minutes sighted for August 2014). Each meeting has the same standing agenda which includes items for reporting and discussion around incident and accident reporting, infection control, complaints and compliments, restraint, health and safety, internal audits, policies and procedures, and in-service education. Resident and family meetings are held two monthly – minutes sighted for August 2014. Discussion is held at residents meetings around food, activities, concerns or complaints, personal cares, and laundry with minutes are held in a folder for reading.
The internal audit programme involves monitoring areas of quality and risk including complaints management, infection prevention and control, health and safety, and restraint minimisation. Various aspects of the service are regularly monitored with examples including resident and family satisfaction surveys (annual), care plan audits (six monthly), medication (six monthly), cleaning (six monthly), laundry (annually), activities programme (annually), food service (six monthly) and the restraint minimisation programme (annually). Monthly internal audit are conducted around admissions, resident hygiene and cares, and building compliance. A process to measure achievement against the quality and risk management plan is in place. The facility manager and quality coordinator/enrolled nurse is responsible for ensuring all internal audits are completed. Tasks are delegated to the registered nurses and to staff where appropriate. On review of the completed audits for 2013 and 2014 year-to-date, it is noted that the actual audits are being completed as per the audit schedule.
Data that is collected is analysed, evaluated and communicated to staff. Corrective actions are put into place where opportunities for improvements are identified. Results of

the internal audits are discussed in the monthly staff meetings, and monthly management meetings.
The facility manager oversees all quality initiatives with support from the management team.
Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted).
D10.1: Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.
D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management
D19.2g: Falls prevention strategies include sensor mats and duo alarms, they are closely observing residents who are at risk of falling, use of mobility aids, physiotherapy assessment and plans, correct footwear and exercises.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D19.3b; There is an accident and incident reporting policy and procedure that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. There is strong culture of reporting at Marne Street Hospital as evidenced on review of the incident/accident folder. Staff interviewed (four registered nurses and six caregivers) were able to describe their involvement in the reporting processes. Incident reports are written for all

events – minor and major including but not limited to missing laundry items, telephone not working, resident and family feedback.
Adverse events (including but not limited to: falls, skin tears, bruising, burns, pressure areas, restraint, challenging behaviours, and medication errors) are documented on an incident form by the person witnessing the event. Further assessment and follow up of the resident involved is conducted by a registered nurse. Data is collected and collated on a monthly basis. Results are communicated to staff at the staff meetings (meeting minutes sighted).
Nineteen incident forms were reviewed for August 2014 relating to seven residents and included nine falls, six incidents of behaviours, two skin tears, and two pressure areas. Staff advised that they contact family following an incident or accident and this is evident in incident forms or progress notes reviewed. Adverse events include an investigation. Follow up is conducted by the registered nurse and GP is notified if required. Either the clinical manager or facility manager investigates all events with further follow up by the facility manager if required. Appropriate clinical follow up is conducted as evidenced on the sample of incident reports reviewed and included observations, assessments, referral as required and short term care plans. The incident form documents the follow-up actions taken. Monthly incident/accident analysis is conducted and results discussed at staff meetings. Annual collation and analysis of reports is conducted.
Statutory and regulatory obligations are understood by the owners and facility manager. Examples include notification to the appropriate authorities in regards to serious injuries, coroner's inquests, changes in management and any complaints lodged with the Health and Disability Commissioner.

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): 60 *(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:

There are 63 staff employed by Marne Street Hospital which includes a facility manager, a clinical manager, a quality coordinator, registered nurses, caregivers, laundry, housekeeping and kitchen staff and the diversional therapist. Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file. Current practising certificates were sighted for the registered nurses, enrolled nurse, physiotherapist, GP and podiatrist.
Eight staff files were randomly selected for review (one clinical manager, two registered nurses, one enrolled nurse, three caregivers and the diversional therapist). Each staff file audited included evidence of a signed employment agreement and position description, appropriate qualifications, evidence of a completed orientation programme including evidence of competency. Registered nursing staff have a current first aid certificate. Staff undergo initial and annual performance appraisals, evident in seven of eight staff files. One staff member file reviewed commenced employment in the past three months.
Marne Street Hospital has an orientation programme that is specific to worker type and includes manual handling, health and safety, and competency testing. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. There is a designated caregiver educator who has responsibilities for ensuring that all new care staff have a comprehensive orientation. New staff must demonstrate competency before working independently (evidenced in the completed orientation checklists for one new caregiver). Interviews with six caregivers confirm their orientation to the service was thorough. All eight staff files reviewed reflected evidence of an orientation programme that had been completed.
Discussion with the registered nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 with a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually.
Caregivers have completed either the national certificate in care of the elderly, the ACE training programme, the Care Training online or are working towards completion. The facility manager is a certified trainer and assessor for the ACE programme.
A system is in place to identify, plan, facilitate and record ongoing education for staff. All staff are required to attend training for the following: fire safety and evacuation, infection control, restraint minimisation, first aid, manual handling and topics relating to the code of rights including privacy, informed consent, the complaints process and open disclosure. Education is provided either as face to face sessions, self-directed reading, completion of questionnaires and learning or attendance at off-site sessions.
Two registered nurses have attended interRAI training. Attendance rates are recorded and evidence good levels of attendance by staff.
Registered nurses competencies available include medication administration knowledge and observed practice, catheterisation, and syringe driver. A tracking process is in place to ensure those who administer medications complete their annual medication competencies.

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:

A good employer policy is in place which includes staffing levels and skills mix. Staffing rosters were sighted. Part time and casual staff fill casual shifts and no agency staff are utilised. The facility manager and clinical manager works fulltime. Registered nurses are rostered on every shift. Care staff interviewed advised that they are well supported by owners, facility manager and the registered nurses.

Roster includes either two registered nurses or one RN and one EN during the week (also includes the facility and clinical manager and quality coordinator) with 10 caregivers who work long and short shifts. There are two RN's on duty in the afternoon with six caregivers who work long and short shifts. Overnight there is one RN and two full shift caregivers. Registered nurses are also provided with one day every six weeks to maintain documentation and care planning. There are three kitchen hands on every day to cover from 0630 – 2030 hours. Activities are provided from every day.
Staff turnover is reported by the facility manager as low. Staffing levels are altered according to resident numbers and acuity. The service is adding on two new resident

rooms and advised by the owners and facility manager that staffing levels will be adjusted as these rooms are completed and filled.
One general practitioner was interviewed who confirms that staffing is appropriate to meet the needs of residents.
Ten residents and seven relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
D7.1 entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.
Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Prior to entry to Marne Street Hospital and Hospital potential residents, have a needs assessment, completed by the needs assessment and co-ordination service, to assess suitability for entry to the service. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The

information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The admission policy describes the declined entry to services process. Marne Street Hospital and Hospital records the reason for declining service entry to residents when this occurs and communicates this to residents/family/whānau and refers the resident/family/whanau back to the referral agency as confirmed by the facility manager.

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:

D16.2, 3, 4: The eight files reviewed (six hospital and two YPD) identified that a nursing assessment was completed within 24 hours. Eight files reviewed identify that the long-term care plan is completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse and amended when current health changes. Seven care plans evidenced evaluations completed at least three monthly including MDT meetings. One hospital resident has been at the service less than three months.

There is sufficient information gained through the initial support plan, specific assessments, the short-term care plan, and the long-term care plans in all files reviewed to guide staff in the safe delivery of care to residents.

Activity assessments and the diversional therapy care plans have been completed by the diversional therapist. Residents interviewed stated that they and their family were involved in planning their care plan and at evaluation. Resident files included family/whanau contact.

D16.5e: Eight resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and were to be reviewed three monthly. More frequent medical review was evidenced occurring in files of residents with acute conditions and residents receiving palliative care. The GP visits twice a week on Tuesday and Thursdays and he confirms on interview that he has confidence in the registered nurses to carry out his instructions and contact him in a timely manner. The GP is available on call.

A range of assessment tools were completed in resident files on admission and completed at least three monthly including (but not limited to); a) falls risk assessment b) pressure area risk assessment (Waterlow), c) continence assessment (and diary), d) cultural assessment, e) skin assessment, f) and nutritional assessment (MNA), and g) pain assessment.

Staff could describe a verbal handover at the start of each duty that maintains a continuity of service delivery. All resident files reviewed identified integration of allied health and a team approach.

Tracer Methodology:

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

Tracer YPD *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 initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks. Personal needs information is gathered during admission including but not limited to: nutrition and diet, continence, oral care, hearing, sleep patterns, restraint, falls risk, mobility, cognitive ability, activities of daily living, pain, communication, skin integrity, tobacco/alcohols use, hairdressing requirements and advance directives. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner and nurse practitioner, support services and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed three monthly. In addition the registered nurses complete a head-to-toe assessment of the resident that includes checking finger nails, toe nails, scalp, behind the ears, eyes, feet, oral health and facial hair required to be removed. Pain assessment was evidenced completed with on-going monitoring recorded for residents requiring administration of controlled medication as part of prescribed pain management plan. The service is gradually changing to use InterRAI assessments and 13 residents have an InterRAI assessment completed so far. Seven family (six from the hospital and one YPD) and 10 residents interviewed (nine from the hospital and one YPD) interviewed are very satisfied with the support provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A review of eight resident files identify the use of short term and long term care plans. These reflect variances in resident health status. Eight of eight are current and include interventions relating to all identified areas of need. There is evidence of three monthly review for seven files reviewed (One hospital resident has been at the service less than three months) which is signed by a registered nurse.

The care plan is completed within three weeks of admission by the registered nurses providing an holistic approach to care planning with resident and family input ensuring a resident focussed approach to the whole process. This is supported by other allied health care professionals providing input such as physiotherapist, dietitian and podiatrist.

D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations.

All eight resident files reviewed identified that family were involved. Family contact sheets located at the front of residents' files demonstrated communication with family/EPOA.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents' care plans are completed by the registered nurses. All eight care plans sampled evidenced that care plans reflect the level of care required. Care delivery is recorded by caregivers on each shift and follow up by registered nurses is documented for any changes in residents condition reported as sighted in progress notes reviewed. The registered nurse initiates a review and if required, GP or specialist consultation when there is a change in residents' condition. The six caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including hoists, duo alarms, slippery sams, electric beds, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Supplies of continence and wound care products were sighted.

D18.3 and 4 Dressing supplies are available and a treatment rooms are well stocked for use. Wound assessment and wound management plans are in place for 15 residents with 20 wounds. Wounds include; one grade III and one grade II pressure area. All wound pressure areas have pressure-relieving devices documented within their wound management plan, pressure relief monitoring charts/turning charts and have been referred to GP. Nutritional assessments have been reviewed. An Incident/accident form was evidenced completed for a grade all pressure areas. The four registered nurses and clinical manager interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Wound and skin care education has been provided February 2014 (17 attended). Wound care audit has been completed in June 014 resulting in 98%.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services occurred in October 2013 with 25 staff attending. The facility has registered nurse cover 24/7 and has a comprehensive 'in service' education programme.

A physiotherapist is contracted to work eight hours per week and more as required.

During the tour of facility it was noted that all staff treated residents with respect and dignity, consumers and families were able to confirm this observation.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The qualified diversional therapist (DT) provides an activity programme that meets the individual physical and cognitive abilities of the residents. The DT works 31 and half hours per week Monday-Friday. The DT attends the regional support group in Dunedin and has attended the divisional therapy conference 2014. An activity person works afternoon hours on Friday, Saturday and Sunday. There are 10 volunteers who assist with the delivery of the programme. Volunteers complete and orientation (sighted). The DT develops the activities programme and every resident has a copy of the two weekly programme. The programme is also displayed on notice boards and activities for the day are written on the white board. The activities programme includes games, films, music, gardening, men's club (includes woodwork), speakers, coffee mornings, women's club, outdoor activities, housie and art club. There is one on one time for those residents unable to participate or who choose not to take part in-group activities. Residents are encouraged to maintain their links with the community and transport is arranged as required. There are links with local church groups, schools, RSA club and kindergartens. School Students assist with the activity programme as part of school development programmes. On admission the DT completes an activities assessment for all residents and within three weeks the activities/diversional care plan is developed. Daily progress notes are maintained in each residents file with documentation of activities attended. The diversional therapy care plan is reviewed at three monthly care plan review. During the audit residents were observed participating in various activities including entertainment, games, and exercises. The two YPD files reviewed and one YPD resident interviewed confirmed the programme also met the individual needs of the younger residents through MS society, day programmes, community gardening groups including, CCS and blind foundation. Residents interviewed were positive about the activities programme. Feedback regarding activities is gained from the two monthly resident/relatives meetings (DT attends and also at the residents advocate) and the resident's annual survey (November 2013). Feedback is generally positive.

The activities programme is also structured to suit rest home residents as well.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is at least a one- three monthly review by the medical practitioner. D16.4a Long-term care plans are reviewed and evaluated by the registered nurses three monthly or when changes to care occur as sighted in care plans sampled. There is at least a three monthly medication review by the medical practitioner.

There are short term care plans to focus on acute and short-term issues. Changes to the long-term care plan are made as required and at the three monthly review if required. Examples of STCP's use included; infections, wounds, challenging behaviours, and unexplained weight loss.

ARC D16.3c: All initial care plans were evidenced to be evaluated by a registered nurse within three weeks of admission.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurses and clinical nurse manager described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC, occupational therapist, mental health services, nurse practitioner, dietician and wound care nurse.

D16.4c: The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care.

D 20.1; Discussions with the registered nurses and clinical nurse manager identified that the service has access to wound care nurse specialists, incontinence specialists, podiatrist, nurse practitioner, mental health service, hospice nurses, occupational therapist and physiotherapist.

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 are policies to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

Family contact records document regular communication with family/EPOA regarding the transfer and updates on residents' condition.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Medication policies align with accepted guidelines. Medications are stored in locked trolleys in the treatment room. Controlled drugs are stored in a locked cupboard in the locked treatment room and two people (one an RN) must sign controlled drugs out. Weekly checks of controlled drugs are carried out. The service uses pharmacy blister packed medications, which is delivered four weekly. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.

Staff sign for the administration of medications on medication sheet. The two medication folders reviewed include a list of specimen signatures and competencies.

The registered nurses and enrolled nurses administer medications. Competency tests are completed six monthly and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medication management training was held in June 2014.

There are currently four residents self-administering medications (Inhalers only). An assessment of resident's ability to self-administer inhalers was sighted completed for all three residents and signed by the GP and evidences review occurring three monthly.

Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name.

Two registered nurses were observed administrating medications safely and correctly. All eye drops are dated on opening.

D16.5.e.i.2; Fifteen of 16 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. One medication chart reviewed is for a recent admission. Medication audits are completed six monthly (May 2014 98%).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are food policies/procedures for food services that include but not limited to: Food Service, menu planning, food handling and preparation, resident nutrition and hydration, and food hygiene. All food is brought into the hospital from ACE Foods. The food is delivered in a hot box and served from the two kitchen areas. The menu is dietician approved and is on a four-week rotation. There are summer and winter variations. Nutritional needs and preferences are included in the assessment process at the time of admission. ACE foods provides alternative individual meals when a meal is unsuitable or disliked by a resident. Diets include two resident that are lactose intolerant and one resident that is dairy and gluten intolerant. Coloured notices are evident on alert staff the resident allergies/intolerances. The service prepares breakfast. Morning/afternoon teas, lunch and dinner are provided by ACE. Food safety training is arranged for all food services staff by ACE (May 2014). Food temperatures are monitored and recorded before serving. Refrigerators and Freezer have thermometer alarms, and daily temperatures are recorded. The kitchen environment is clean and well maintained. There are cleaning schedules available. Food is stored appropriately and within expiry dates.

The lunchtime meal was observed being served. Residents interviewed reported satisfaction in the quality of meals being served and that their likes and dislikes are known by staff.

Caregivers were observed assisting those residents who needed assistance with food and fluid intake at lunchtime. The residents were not rushed and the meals were kept hot until there was a staff member free to assist. Some residents were served their meal in their rooms. Equipment available such as lipped plates, sipper cups and special cutlery.

There is enough space for rest home residents to sit together with or apart from hospital residents if required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. These include (but are not limited to): needles and sharps policy; chemical storage policy; waste disposal policy. There is an incident reporting system that includes investigation of incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were evidenced stored securely in locked cleaning cupboards.

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: PA Low

Evidence:

Reactive and preventative maintenance occurs. Fire equipment is checked by an external provider. The building holds a current warrant of fitness, which expires 17 October 2014. Electrical equipment is checked (September 2014). The living areas are carpeted or vinyl and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and gardens area is attractive. The garden/decking area has furniture and umbrellas provide shade. There is wheelchair access to all areas.

Hoists are serviced annually and this last occurred in September 2014. Equipment was last calibrated in September 2014. .

The service has applied for reconfiguration of services (as per MOH letter dated 27 May 2014) with the addition of two extra hospital rooms. On the day of the audit the rooms sighted as being partially completed. The rooms are expected to be fully completed early November with call bell, heating, lighting, toilet/shower and furniture prior to occupancy.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, electric beds heel protectors, lifting aids

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The service has applied for reconfiguration of services (as per letter MOH dated 27 May 2014) with the addition of two extra hospital rooms

Finding:

On the day of the audit the two rooms were partially completed.

Corrective Action:

Ensure that prior to occupancy a code of compliance is completed and the rooms are fully equipped with call bell, heating, lighting, toilet/shower and furniture.

Timeframe (days): Prior to occupancy *(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 communal toilets and showers close to bedrooms. Some rooms have full ensuites, some rooms have shared ensuites and some have hand basins only. Toilets are located close to dining rooms and lounges for residents' use. A visitor's toilet is available. Water temperatures are tested (10 rooms) three monthly by the maintenance person and records show they are within safe limits. Residents, families and caregivers report adequate numbers of toilets and showers in each area.

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:

Observation on day of audit demonstrated walking frames, hoists and other required equipment can be manoeuvred around the residents' personal space, this was confirmed at interview with caregivers. Some rooms have overhead hoists fitted. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists.

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:

There are several large lounges and dining areas. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit and residents interviewed report they can move around the facility and staff assist them if required.

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:

All laundry is completed on site by dedicated laundry staff. Chemicals are stored in a locked room in laundry. All chemicals are labelled with manufacturer's labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. A cleaning and laundry audit occurred in May 2014 attaining 98% compliance.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures and training for civil defence, other emergencies and security. Emergency training is included in all new staff orientation. All shifts have a trained first-aider (RN). The New Zealand Fire Service approved the fire evacuation scheme on the 10 February 2000 and this was amended and updated on the 13 May 2005 following additions to the building. Fire evacuation drills have occurred six monthly - last conducted on 25 August 2014. A civil defence emergency kit is readily available and there is sufficient water stored in case of emergency (10,000 litres). Battery operated emergency lighting, extra torches and gas cooking and gas hot water and is in use/available. The service is able to obtain a generator from within the community if required in an emergency. Fire alarms and hose reels are checked by a contracted company. Testing and tagging of electrical appliances was last conducted on 9 September 2014. Call bells are evident in resident's rooms, dining and living areas, corridors and toilets/bathrooms and is linked to the telephone system. Staff carry phones with them which alert them to a resident call bell. Security policies and procedures are in place. There is a procedure for additional resident supervision to maintain safety. The service has extra food and water available should the need arise.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The facility has heating in hallways, bedrooms and communal areas. The temperature can be adjusted to suit individual resident temperature preference. Rooms are well ventilated and windows provide natural light. Facility temperatures are monitored. Ten residents interviewed stated the temperature of the facility was comfortable

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the clinical nurse manager, six caregivers, one enrolled nurse, and four registered nurses.

There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures

The process of assessment and evaluation of enabler use is in place. Currently there are 10 restraints for nine residents (eight bed rails and one lap belt) and 10 residents using 13 enablers (10 bedrails and three lap belts). On review of the files (four enablers and four restraint). Included in the file is an assessment process that covers alternatives and least restrictive options. The enablers and restraint is also linked to the resident's care plan.

A register for each restraint/enabler is completed that includes a three-monthly evaluation.

There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings. A restraint audit completed in August 2014 attained 100% compliance. Restraint education has been completed in In September 2014. Staff have restraint competencies completed six monthly.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

The restraint coordinator is an RN experienced in aged care and has been at the service for five years (job description for restraint coordinator sighted). Assessment and approval process for a restraint intervention includes the RN, resident/or representative and medical practitioner.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the eight files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family/whanau involvement and a specific consent for restraint form is used to document approval. These were sighted in the four restraint files reviewed.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The four files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the four files reviewed. Four files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. Assessments are completed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month.

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The service has documented evaluation of restraint every month. The restraint process considers the items listed in # 2.4.1. In the four restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every monthly by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Marne Street Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by the facility manager and infection control nurse (quality coordinator/enrolled nurse). The RN/quality committee incorporates the infection control committee. Discussion and reporting of infection control matters and consequent review of the programme is conducted at these meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (May 2014). Annual review of the 2013 programme was conducted in September 2014. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

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 quality coordinator/enrolled nurse is the infection control (IC) nurse. She is supported by the owners, facility manager, clinical manager, registered nurses and care staff. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The enrolled nurse has attended infection control training relating to outbreak management (May 2014) and general infection prevention and control with Bug control (November 2013). The IC nurse and staff have good external support from the local laboratory infection control team and IC nurse expert at Southern DHB. The infection control team is representative of the facility.

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:

There are infection control policies and procedures appropriate to for the size and complexity of the service.
D 19.2a: The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed and updated by the facility manager, IC nurse and clinical manager to ensure best practice information is included. The policies and procedures were last updated and reviewed in August 2014. Marne Street Hospital 's infection control policies include (but not limited to): hand hygiene, standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse (EN). All infection control training is documented and a record of attendance is maintained. Infection control education was provided in May 2014 in relation to hand washing and hand hygiene, waste management and correct use of personal protective equipment. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Residents are informed of infection prevention matters that are appropriate to their needs and this is documented in medical records. The enrolled nurse has attended Bug control infection control education in November 2013 and outbreak management at the DHB in May 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:

Infection surveillance is an integral part of the infection control programme and is described in Marne Street Hospital's infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the management meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. No outbreaks have been reported in the past two years.

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.)*