

# Dixon House Trust Board

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Current Status: 20 October 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

Dixon House is owned and operated by the Dixon House Trust Board. The service is certified to provide rest home level care for up to 40 residents with 38 residents accommodated on the days of audit. There are documented mission, values and goals for Dixon House. The manager is a registered nurse who has been in the role for three years. She is supported by an external quality consultant, the board secretary, a quality manager, registered and enrolled nurses and care staff. The service has introduced a new quality management system which includes new policies and procedures. The service is actively working towards implementing the new system and continues to provide resident focused care. Residents and families interviewed were supportive of the care and support provided.

This audit has identified improvements required around recording of communication with families, reporting all adverse events and maintaining incident records, signing and dating of all records, aspects of care planning and implementation of interventions, aspects of medication management, displaying a current building warrant of fitness, ensuring fire drills are conducted six monthly, and aspects of restraint documentation and monitoring.

## Audit Summary as at 20 October 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

### Consumer Rights as at 20 October 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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### Organisational Management as at 20 October 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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### Continuum of Service Delivery as at 20 October 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 20 October 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 20 October 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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## Infection Prevention and Control as at 20 October 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 20 October 2014

### Consumer Rights

Policies and procedures are in place that meet the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information for advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau. Families and residents interviewed confirmed that the service communicates appropriately, however improvements are required whereby this is recorded on all occasions. Informed consent processes are followed and advanced directives are recorded. Complaints and concerns are actively managed and logged in a complaints register.

### Organisational Management

The service has introduced and is in the process of implementing a new quality management system. An external consultant has provided the service with new policies and procedures and the service is managing the process around introducing this to staff. The system includes a comprehensive quality and risk management system which includes analysis of incidents, infections and complaints, internal audits and feedback from the residents.

Key components of the quality management system link to quality and staff meetings. The home manager and quality manager are responsible for the quality programme. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan for 2013-2015, with a quality and risk plan for 2014. The service has policies and procedures to provide appropriate safe quality care to people who use the service. Improvements are required whereby all adverse events are reported via the incident reporting system. There are implemented health and safety policies that include hazard identification.

The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be

referenced and retrieved in a timely manner. Improvements are required whereby all records and documents are signed and dated by staff making the entries.

### **Continuum of Service Delivery**

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to aspects of care planning and implementing interventions.

The medication management system includes policy and procedures that follows recognised standards. An improvement is required whereby medication charts are completed appropriately and documented procedure is followed. Staff responsible for medication administration receive training and competencies are conducted annually. Resident medications are reviewed by the residents' general practitioner at least three monthly.

A range of activities are available in the rest home and residents provide feedback on the programme.

Dixon House has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff complete food safety training.

### **Safe and Appropriate Environment**

Dixon House has a building warrant of fitness which expired on 1 July 2014. Improvements are required in this area. Maintenance is carried out. Chemicals are stored in a locked storage container and in the locked laundry and hot water temperatures are monitored and recorded. Medical equipment is calibrated by an authorised technician.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies and procedures for civil defence and other emergencies. Improvements are required whereby six monthly fire drills are conducted. A generator, emergency lighting, gas heating, BBQ are available in the event of a power failure.

Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

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

The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the days of audit there was one resident who has recently been assessed as requiring restraint and no residents with enablers. Improvements are required whereby all documents relating to restraint are fully completed including monitoring of restraint when in place. Staff have attended restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually.

### **Infection Prevention and Control**

The infection control programme is well established at Dixon House rest home. An enrolled nurse is the infection control coordinator with support from the quality manager/RN. The infection control team comprises of all staff. Regular audits that include hand washing and cleaning are conducted and provide feedback to the staff. 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 at quality and staff meetings. Education is provided to staff annually and as surveillance results indicate extra training is required.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Dixon House Trust Board
<b>Certificate name:</b>	Dixon House Trust Board
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Dixon House Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 20 October 2014 <b>End date:</b> 21 October 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	38

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	24	Total audit hours off site	11	Total audit hours	35
Number of residents interviewed	8	Number of staff interviewed	12	Number of managers interviewed	1
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	1
Number of medication records reviewed	14	Total number of staff (headcount)	38	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Monday, 3 November 2014

## Executive Summary of Audit

### General Overview

Dixon House is owned and operated by the Greymouth combined churches community Trust board. The service is certified to provide rest home level care for up to 40 residents with 38 residents accommodated on the days of audit. There are documented mission, values and goals for Dixon House. The manager is a registered nurse who has been in the role for three years. She is supported by an external quality consultant, the board secretary, a quality manager, registered and enrolled nurses and care staff. The service has introduced a new quality management system which includes new policies and procedures. The service is actively working towards implementing the new system and continues to provide resident focused care. Residents and families interviewed were supportive of the care and support provided.

This audit has identified improvements required around recording of communication with families, reporting all adverse events and maintaining incident records, signing and dating of all records, aspects of care planning and implementation of interventions, aspects of medication management, displaying a current building warrant of fitness, ensuring fire drills are conducted six monthly, and aspects of restraint documentation and monitoring.

### Outcome 1.1: Consumer Rights

Policies and procedures are in place that meet the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information for advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau. Families and residents interviewed confirmed that the service communicates appropriately, however improvements are required whereby this is recorded on all occasions. Informed consent processes are followed and advanced directives are recorded. Complaints and concerns are actively managed and logged in a complaints register.

### Outcome 1.2: Organisational Management

The service has introduced, and is in the process of implementing, a new quality management system. An external consultant has provided the service with new policies and procedures and the service is managing the process around introducing this to staff. The system includes a comprehensive quality and risk management system which includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. Key components of the quality management system link to quality and staff meetings. The home manager and quality manager are responsible for the quality programme. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan for 2013-2015, with a quality and risk plan for 2014. The service has policies and procedures to provide appropriate safe quality care to people who use the service. Improvements are required whereby all adverse events are reported via the incident reporting system. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is a comprehensive orientation programme that provides

new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner. Improvements are required whereby all records and documents are signed and dated by staff making the entries.

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Improvements are required in relation to aspects of care planning and implementing interventions. The medication management system includes policy and procedures that follows recognised standards. An improvement is required whereby medication charts are completed appropriately and documented procedure is followed. Staff responsible for medication administration receive training and competencies are conducted annually. Resident medications are reviewed by the residents' general practitioner at least three monthly. A range of activities are available in the rest home and residents provide feedback on the programme. Dixon House has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded. Kitchen staff complete food safety training.

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

Dixon House has a building warrant of fitness which expired on 1 July 2014. Improvements are required in this area. Maintenance is carried out. Chemicals are stored in a locked storage container and in the locked laundry and hot water temperatures are monitored and recorded. Medical equipment is calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout the facility. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that allows residents to mobilise. There is a designated laundry which includes storage of cleaning and laundry chemicals. Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies and procedures for civil defence and other emergencies. Improvements are required whereby six monthly fire drills are conducted. A generator, emergency lighting, gas heating, BBQ are available in the event of a power failure. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	A sample of incidents forms and associated resident files reviewed, does not evidence that family/next of kin are always contacted following adverse events. Communication with family is not well documented on incident reports or in the resident files reviewed.	Provide evidence that family/next of kin are contacted following incidents and accidents as per service policy.	90
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	a) Three of six incident report forms for September 2014 could not be located in resident files and therefore could not evidence that appropriate care and follow up has been provided and recorded; b) two pressure injuries which had developed have not been reported via the incident reporting system as per service policy and procedures	a) Maintain records of incidents and accidents to evidence that appropriate care and response is conducted and recorded; b) where pressure injuries develop, ensure that these are reported via the incident reporting system as an adverse event.	90
HDS(C)S.2008	Standard 1.2.9: Consumer Information	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management Systems	accessible when required.				
HDS(C)S.2008	Criterion 1.2.9.9	All records are legible and the name and designation of the service provider is identifiable.	PA Low	On review of seven resident files it is noted that not all documents (assessments, care plans) are signed and dated.	Ensure that all resident related documents are signed and dated at the time of entry.	90
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	(i) Activities care plans were incomplete on four of seven resident files reviewed; (ii) STCPs were not in place for all short term care issues; (iii) one resident's care plan was not updated following a change from self-medicating; (iv) care plan interventions do not always record sufficient detail to guide care staff. These include one resident with behaviour issues and wandering, two with incidence of falls and one with postural drop.	(i) Ensure all residents have activities care plans completed in their clinical file; (ii) ensure interventions to manage acute needs are documented on a STCP or the LTCP is updated; (iii) ensure LTCP's are updated when there is a change in care needs prior to their scheduled review; (iv) ensure all care plan interventions are recorded in sufficient detail to guide care staff.	60
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Policy states weight monitoring to be conducted monthly. Weights are currently undertaken three monthly. However, on review of seven resident files, it is noted that in four of seven files, this is not routinely conducted - with gaps	Ensure all residents are weighed monthly or more frequently as required, and this recorded in their clinical file.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				of up to eight months.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	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.	PA Moderate	On review of 14 medication charts, it is noted that; (i) four of 14 charts do not record indications for use of PRN medication orders. All regular tablet medication is pre-packed by the pharmacy into blister packs. (ii) Out of normal time medications were given to residents without staff checking the medication chart. (iii) Correct procedure was not followed (observed) when administering medications two residents.	(i) Ensure that all medication orders are completed appropriately as per best practice. (ii) And (iii) Ensure policy and procedure is followed by care staff when administering medications	30
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	The service does not display a current building warrant of fitness. The building warrant of fitness expired on 1 July 2014	Provide evidence that the building a current building warrant of fitness and that this is displayed.	60
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to	PA Low	Fire drills have not been conducted six monthly. Fire drills were conducted on 18	Conduct fire drills six monthly as per policy and fire safety training requirements. Next	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		identified emergency and security situations. This shall include fire safety and emergency procedures.		September 2013 and again on the 20 June 2014.	fire drill due prior to or on the 20 December 2014.	
HDS(RMSP)S.2008	Standard 2.2.1: Restraint approval and processes	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.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.1.1	The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.	PA Low	There is a lack of evidence in the resident file to confirm that the GP has been involved in the restraint approval process.	Provide evidence that the GP has been part of the restraint approval process.	90
HDS(RMSP)S.2008	Standard 2.2.2: Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.2.1	In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the	PA Low	Restraint assessment documentation has not been completed for the one resident with restraint (bedrails).	Ensure that restraint assessment documentation is completed for all residents requiring restraint.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>				
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.3.4	<p>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:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	Each episode of restraint has not been documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome.	Ensure that each episode of restraint is monitored and recorded.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the Code) and relevant legislation. Posters and pamphlets are available in reception area of the service. An information pack is available to residents/families prior to admission and contains information of their rights. The staff orientation programme includes the Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers' Rights. Three caregivers and the activity coordinator interviewed could discuss how consumer rights are met during service delivery and gave examples such as privacy, choice and independence. Training on the code of rights was provided in February 2013.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

The code of rights and advocacy pamphlets are located at the main foyer. The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents e.g. large print, tapes and videos. On admission the manager or the registered nurse discusses the information pack with the resident and the family/whānau. This includes the Code of Rights, complaints and advocacy. Residents interviewed (eight) stated they were well informed about the code of rights and the service provides an open-door policy for concerns/complaints.

D6, 2 and D16.1b.iii the information pack provided to residents on entry includes how to make a complaint, COR pamphlet, and advocacy 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:**

The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff interviewed (one registered nurse, one enrolled nurse and three care givers) can describe the procedures for maintaining confidentiality of resident records. Discussions with residents (eight) and family members (three) identified that personal belongings are not used as communal property. The staff were respectful of entering a resident's room and gained permission by knocking on doors before entering.

There is a weekly church service for residents and residents are supported to attend their own church in the community. Daily devotions are also held.

There is an intimacy and sexuality policy with an in-service conducted in March 2014. Spirituality in service was provided to staff in September 2014. There is an abuse and neglect policy. Elder abuse and neglect training was provided in August 2014. Discussions with the home manager, the quality manager, registered nurse, activities coordinator and caregivers (three), and a review of incident forms, identified that there were no incidents of abuse or neglect and they could describe situations that would be considered abusive or neglectful.

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

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

D4.1a: Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. As part of care planning, there is a section on social history and personal relationships which refers to respect of residents privacy, quality of life and social contacts.

On a tour of the facility it was noted that residents are addressed by their preferred name. Residents interviewed (eight) confirmed that staff speak respectfully to them and call them by their preferred name. Resident's files and care plans identify residents preferred names.

**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.1.3.2 (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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.1.3.6 (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.

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

Cultural safety policy includes meeting the needs of Maori residents, with local input from Maori representatives. There is currently no residents at Dixon House who identify as Maori. Discussions with relatives (three) all identified that values and beliefs were considered. Discussions with eight residents confirmed that staff took into account their culture and values. Cultural safety training was provided in July 2014.

A3.2: There is a Maori health plan and ethnicity awareness policy which includes definitions of Treaty of Waitangi, care after death, health consultations networks, local iwi, local Maori health groups and services, Marae contacts, health social services, wardens and welfare leagues contact details and descriptions of how to ensure that the service providers 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:**

D3.1g: The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a policy for recognition of individual values and beliefs. Discussions with residents (eight) and relatives (three) confirmed that staff considered their individual values and belief. Family are involved in the gathering of information about the history of the resident as appropriate. Staff interviewed (three caregivers, one enrolled nurse, one registered nurse, activity coordinator and the home manager) were aware of differences in other cultures and how to access assistance if required e.g. support for the resident and interpreter services. Contact details for interpreter services is available.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Education regarding the code of rights, advocacy and open disclosure was completed in April 2014. The employment agreement includes a code of conduct and acceptance of gifts policy. Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct all staff are required to read and sign before employment. Qualified staff are in addition also required to abide by a professional code of ethics. All staff have job descriptions appropriate for the role and these include responsibilities of the position.

### **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:**

A2.2: Services are provided at Dixon House that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. There are four monthly staff meetings that include; training, restraint, incidents and accidents, infection control, quality improvement, health and safety, and general business. Residents and families spoke positively about the care provided.

D1.3: all approved service standards are adhered to.

D17.7c: There are implemented competencies for caregivers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. Professional boundaries are discussed as part of the orientation to the service. The service supports and encourages staff to attend education both internally and externally.

### 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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** PA Low

### Evidence:

Information pack is provided at entry to residents and family/representatives and includes general information relating to the services provided at Dixon House, advocacy information, Health and disability code, code of rights policy and complaints policy and form. Families interviewed (three) confirmed they are involved in the initial care planning and in on-going care. Access to interpreter services is identified in the community.

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

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

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

D16.4b: Interviews with three relatives confirmed that they are informed when their family members health status changes, however, a sample of incidents forms and associated resident files reviewed, does not evidence that family are contacted at all times. Improvements are required in this area. Four monthly resident meetings held includes feedback to the service. Resident/relative satisfaction survey (December 2013) reflected communication was effective and occurred regularly.

## 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:** PA Low

### Evidence:

Information pack is provided at entry to residents and family/representatives and includes general information relating to the services provided at Dixon House, advocacy information, Health and disability code, code of rights policy and complaints policy and form. Families interviewed (three) confirmed they are involved in the initial care planning and in on-going care. Access to interpreter services is identified in the community. Interviews with three relatives confirmed that they are informed when their family members health status changes. Four monthly resident meetings held includes feedback to the service. Resident/relative satisfaction survey (December 2013) reflected communication was effective and occurred regularly.

### Finding:

A sample of incidents forms and associated resident files reviewed, does not evidence that family/next of kin are always contacted following adverse events. Communication with family is not well documented on incident reports or in the resident files reviewed.

### Corrective Action:

Provide evidence that family/next of kin are contacted following incidents and accidents as per service policy.

**Timeframe (days):** 90 (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:**

Dixon House has policies and procedures relating to informed consent and advanced directives. Informed consent training was provided for staff in April 2014. A review of seven files identified that seven of seven files included signed informed consent forms to allow for taking of photographs, displaying the residents name on a list at the main entrance, collecting health information and outings as part of the admission process and agreement. There is a resuscitation form and process. Resident files reviewed had completed resuscitation documentation. There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with three families identified that the service actively involves them in decisions that affect their relatives' 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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

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

Resident access to advocacy meets the requirements of the Code of Health and Disability Services Consumers' Rights. Information provided to residents at the time of entry to the service provides residents and family/whanau with advocacy information. The information identifies who the resident can contact to access advocacy services. Staff interviewed are aware of the right for advocacy. Pamphlets are available in foyer area. Advocacy, open disclosure and informed consent training was provided to staff in April 2014.

D4.1d; Discussion with three family identified that the service provides opportunities for the family/EPOA to be involved in decision.

### **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:**

Family members (three) and residents (eight) confirm that visiting can occur at any reasonable time. Discussions with staff, residents and relatives identified that the service encourages residents to belong to community groups.

D3.1h: Discussion with three family confirmed that they are encouraged to be involved with the service and care

D3.1.e: Discussion with eight residents, three care staff and the activities coordinator confirm that the residents are supported and encouraged to remain involved in the community and external groups such as church services, entertainers and school children visit.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints procedure is provided to resident/relatives at entry and is available with complaint forms at the reception area. There is a complaints register that is up to date and includes relevant information regarding the complaint (two in 2014). Documentation including follow up letters and resolution demonstrates that complaints are well managed and verbal complaints are also included that identify actions and response. Issues that are identified at resident meetings or resident surveys are recorded in the complaints register.

D13.3h: A complaints procedure is provided to residents within the information pack at entry. The complaints procedure is provided to relatives on admission. Eight residents and three family members stated that they were informed of the complaints process and that they felt confident that their concerns and issues would be dealt with appropriately by staff and management.

Complaints are reported to the board, quality/clinical meetings and to the general staff meetings.

### **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:**

Dixon House is located in Greymouth and is owned and operated by a combined churches charitable Trust. The Dixon House manager reports monthly to the Trust board. The Board secretary advised that the Trust is comprised of representatives of the four churches involved, along with community and clinical representation. The manager has been in the role for three years, and is a registered nurse with experience in management and mental health. Dixon House is certified to provide rest home level care to 40 residents with 38 residents accommodated on the day of audit. The service is also contracted by the local DHB to provide care for up to six residents with diagnoses of dementia. These residents are assessed as rest home level care but the DHB is funding for extra care staff hours with one to one staffing provided for these six residents during the afternoon/evening period. The Dixon House Trust board has a constitution for organisational governance and direction with a business plan in place. The service has introduced a new quality management system with associated policies and procedures in November 2013 and has the assistance of an external consultant for advice and implementation of the new system. There is a quality and risk management plan in place. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plan. The mission statement of the organisation is included in the admission documentation.

**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:**

The service employs an experienced registered nurse as a quality manager. This person is delegated with the responsibility of fulfilling the manager role in her absence, and also provides clinical support to the RN. The quality manager has many years' experience in aged care management roles. The service has comprehensive policies and procedures in place and service delivery is meeting residents assessed needs. Residents interviewed confirmed that the service is meeting their needs.

D19.1a; The service has well developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service. There are relevant care and support policies, including relevant clinical procedures for the management of rest home care. The general practitioner interviewed stated that she is confident with the service provided.

### 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:**

Dixon House has an implemented quality and risk management system with on-going improvements identified. The service has contracted an external consultant, which includes the introduction of external policies and procedure manuals. The new quality management system was introduced in November 2013 and the service has implemented a plan for the introduction of the new suite of policies and procedures. There has been implementation of the new policies occurring, with staff signing a policy and procedure familiarisation acknowledgment form, following the implementation of each manual. On interview, care staff were able to describe the process of introduction of new policies, procedures and associated forms and documents. The service employs a quality manager (RN), who manages the quality programme and works for one day a week as the registered nurse. The policies and procedures and associated implementation systems provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. The service collects internal monitoring data (internal audits). It also collects data in relation to: incidents and accidents, complaints/concerns (where these occur), resident satisfaction, and staff satisfaction. The data collected is analysed to ascertain improvement actions and these are communicated to staff through the staff meetings. Resident meetings occur and a resident survey was conducted in December 2013.

There is a 2013-2015 business plan which the manager and Board chairman has signed. The service has a quality assurance and risk management programme for 2014. The plan reflects the services philosophy and service needs. Quality objectives for 2014 include continued introduction of the new policies and procedures for staff, education and training for staff, providing resident focused services which address assessed needs and preferences while maintaining independence.

There is an internal audit matrix for 2014 and completed audits include: infection control, weight monitoring, admissions, care planning, hygiene and grooming, complaints, activities, environment, continence, medication management, personal privacy and safety, cultural safety, wound care, education, laundry and cleaning and informed consent. There is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and handover times.

A combined quality and clinical meeting occurs four monthly and staff meetings occurring four monthly. Minutes are recorded with an action plan developed around issues identified from internal audits, surveys, incident/accidents, complaints and reports from various areas within the service. The minutes are circulated for staff to read and reported to the general staff meeting. Staff are able to describe their involvement in the process through the staff meetings and being part of the internal auditing and its follow up/outcomes. Staff were also able to describe the process of implementation of the new suite of policies and procedures and associated forms.

Complaints are reported to and managed by the home manager and quality manager.

There is a hazards register which was reviewed in December 2013. Hazards identified have been isolated/minimised, reported to staff through staff meetings and recorded on the hazard register completing the quality circle. The service has security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The service has extra supplies of food, water and equipment available in the event of a disaster.

There is an infection control manual, infection control programme and corresponding policies which require inclusion of antibiotic resistant infections. Infection control is part of the monthly agenda at the general staff meetings. Results of data analysis are reported to the staff through regular staff meetings. Staff feel well informed about infection control at the service. Education and training for staff is conducted around Infection control at orientation, annually and as surveillance results indicate any areas of concern.

There is a restraint minimisation management policy. There is currently one resident with restraint in use at Dixon House (link #2.2). The service's philosophy is to provide a restraint free environment.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.

There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The service has actively removed policies and documents related to the previous quality programme as part of implementing the new system.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the manager and clinical leader who completes the follow up, collates and analyses data to identify trends. Results are discussed with staff through the four monthly staff meeting (link 1.2.4.3).

D5.4: The service has policies/ procedures to support service delivery. Policies and procedures align with the resident care plans.

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 at Dixon House include: care plan review, assessment of level of assistance required, falls risk assessment and monitoring, discussion with resident and family, assessment by occupational therapist and/or physiotherapist, assessment of transferring and mobility, medication and blood pressure review, and ensuring appropriate footwear is worn (link finding #1.3.5.2).

### **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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.2.3.4 (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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**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:** PA Low

**Evidence:**

The service collects incident and accident data. The monthly register of incidents for September 2014 (six) were reviewed and included three falls, two incidents of wandering and one skin tear. On review of related resident files, three of six forms could not be located. Improvements are required in this area. Following discussion with the manager and registered nurse and on review of one of seven resident files reviewed, it was noted that pressure injuries are not reported via the incident reporting system. Two pressure injuries have been identified in 2014. Improvements are required in this area. One of six incident forms reviewed demonstrate that the family had been notified (link finding #1.1.9.1). Incident forms are reviewed by the registered nurse and home manager (registered nurse) who complete necessary investigations and follow up. Incidents are reported to staff via meetings including monthly analysis of: skin tears, resident falls, resident accidents, medication errors, and staff incidents. The service identifies and reports appropriate situations to statutory authorities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service collects incident and accident data. The monthly register of incidents for September 2014 (six) were reviewed and included three falls, two incidents of wandering and one skin tear. On review of related resident files, three of six forms evidenced follow up by the registered nurse and appropriate clinical assessments and care provided. Three of six forms could not be located. Improvements are required in this area. Following discussion with the manager and registered nurse and on review of one of seven resident files reviewed, it was noted that pressure injuries are not reported via the incident reporting system. Two pressure injuries have been identified in 2014. Improvements are required in this area. One of six incident forms reviewed demonstrate that the family had been notified (link finding #1.1.9.1). Incident forms are reviewed by the registered nurse and home manager (registered nurse) who complete necessary investigations and follow up. Incidents are reported to staff via meetings including monthly analysis of: skin tears, resident falls, resident accidents, medication errors, and staff incidents

**Finding:**

a) Three of six incident report forms for September 2014 could not be located in resident files and therefore could not evidence that appropriate care and follow up has been provided and recorded; b) two pressure injuries which had developed have not been reported via the incident reporting system as per service policy and procedures

**Corrective Action:**

a) Maintain records of incidents and accidents to evidence that appropriate care and response is conducted and recorded; b) where pressure injuries develop, ensure that these are reported via the incident reporting system as an adverse event.

**Timeframe (days):** 90 (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 job descriptions available for all relevant positions including: manager, registered nurse, caregiver, activities person, cleaner, kitchen staff and all staff have employment contracts (collective agreement). Human resource policies establish the requirements for vetting of qualifications and the maintenance of practicing certificates for registered nursing staff. A record of practicing certificates is maintained for all health professionals. There are comprehensive human resource policies folder including recruitment, selection, orientation and staff training and development to guide management to ensure that the most appropriate people are recruited for vacant positions.

D17.6, Orientation for new care staff includes a buddy system with an existing staff member. New staff are assigned a 'mentor' who ensures that the orientation checklist is completed and signed off. Records of completion of orientation are retained on staff files and this was evidenced in a newly employed staff file reviewed.

A selection of staff files reviewed included one registered nurse, one quality manager/registered nurse, three caregivers, an enrolled nurse and a relief cook. The service conducts performance appraisals annually for all staff against the relevant job description as evidenced in all seven files reviewed. Three caregiver staff files have relevant qualifications related to rest home care (ACE programme). The service provides the ACE training programme for caregivers.

Training provided in 2014 includes but not limited to: challenging behaviours, restraint, medication management, pain management, spirituality wound care, elder abuse, fire training, cultural safety, continence, civil defence, infection control, open disclosure, personal cares, chemical safety, manual handling, and palliative care. Registered nurses and enrolled nurses administer medications and annual competencies are completed as evidenced in staff files reviewed. Staff files reviewed included individual training attended and documented competencies. Staff development exceeds eight hours per annum.

**Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented staff rationale that outlines the requirements for staffing of the service. The service has a total of 38 staff in various roles. There is currently 38 rest home residents. Staffing rosters sighted and there is staff on duty to match the needs of different shifts.

Policy states that a registered nurse will be on duty/or on call at all times in the rest home. At least one staff member on each shift/duty holds a current first aid certificate. Rosters evidenced caregiver and enrolled nurse mix, with a registered nurse on duty from Monday to Friday and on call after hours and weekends. Registered nursing hours include one RN who works 34 hours per week, one quality manager/RN who completed one x eight hour RN shift per week and the home manager (RN) who works 40 hours per week. An enrolled nurse is rostered on every shift. Care staff interviewed (three) stated that the service currently employs enough staff to cover the care needs of the residents. One enrolled nurse and five caregivers work a mix of short and long shifts in the morning; one enrolled nurse, two caregivers in the afternoon on long and short shifts (plus two activities staff); and one enrolled nurse and one caregiver on overnight on full shifts. The activities coordinator works 38- 40 hours per week. There are designated cleaning/laundry staff and kitchen staff – one cook and two kitchen hands per day. Care staff are also responsible for laundry work.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service retains relevant and appropriate information to identify residents and track records. Information collected on admission has sufficient detail to identify, manage and track resident records for the service. This includes information gathered on admission by the registered nurse with the involvement of the resident, family/whanau. There are resident files in use appropriate to the service. The admission page includes (but is not limited to): date of entry to the service, full name, preferred name, date of birth, gender, NHI number, ethnicity, first contact name and contact details, second contact name and contact details, general practitioner, religion. A nursing assessment and resident register are completed.

There are paper based files appropriate to the service type available. Staff can describe the procedures for maintaining confidentiality of resident records. Resident files and relevant care support information are able to be reference and retrieved in a timely manner.

D7.1 entries in progress notes are legible, dated and signed by the relevant caregiver or RN including designation. Resident care plans and progress notes were legible and recorded regularly. Improvements are required whereby all resident related documents are signed and dated with a designation. Progress notes are written at least daily with documentation in resident progress notes by carers and registered nurses. 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:** PA Low

**Evidence:**

There are paper based files appropriate to the service type available. Staff can describe the procedures for maintaining confidentiality of resident records. Resident files and relevant care support information are able to be reference and retrieved in a timely manner.

D7.1: entries in progress notes are legible, dated and signed by the relevant caregiver or RN including designation. Resident care plans and progress notes were legible and recorded regularly. Progress notes are written at least daily with documentation in resident progress notes by carers and registered nurses. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

**Finding:**

On review of seven resident files it is noted that not all documents (assessments, care plans) are signed and dated.

**Corrective Action:**

Ensure that all resident related documents are signed and dated at the time of entry.

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Three family members and eight residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for seven resident files sampled. The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission 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 service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a policy and process that describe resident's admission and assessment procedures. A registered nurse undertakes the assessments on admission. An initial nursing assessment and care plan is completed within 24 hours of admission. The long term care plan is developed within three weeks of admission. In seven of seven resident files sampled the initial admission assessment and resident comprehensive long term care plans were completed and signed off by a registered nurse. Six monthly reviews are conducted or earlier if resident health changes, and are completed by an enrolled nurse with oversight from a registered nurse or a registered nurse with input from the care staff, the activities coordinator and any other relevant person. Activities assessments and care plans are developed by the activities coordinator. Handover occurs at the end of each duty that maintains a continuity of service delivery. The full time registered nurse works Monday to Thursday and shares after hour's on-call during the weekend. The part time registered nurse works Friday and also shares the provision of after hour's on-call over the weekend.

Medical assessments are completed within two working days of admission by the general practitioner (GP) as evidenced in the medical notes of seven of seven resident files sampled. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. GP interviewed stated that the service provided her with information required to assess residents. The service always carried out any observations and interventions prescribed.

There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment and f) behaviour assessment and monitoring. The interRAI assessment tool is starting to be utilised. Long term care plans reviewed for seven of seven resident's evidence comprehensive and resident focused goals and interventions. All seven files identified integration of allied health including podiatry.

Tracer Methodology:

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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.3.3.3 (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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.3.3.4 (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.

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

An initial nursing assessment and initial care plan is completed within 24 hours of admission. The initial assessment includes: cognitive, sensory, mobility, breathing, hygiene and grooming, skin, continence, oral care, pain, safety and risk, dietary, social/values and beliefs, cultural and spiritual and sleeping. Personal needs, outcomes and goals of residents are identified. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence, b) pressure area risk assessment, c) nutrition, d) falls risk assessment, e) pain assessment, f) behaviour assessment and monitoring.

The interRAI assessment tool is being commenced as the RN's have recently undertaken InterRAI training. Assessments are conducted in an appropriate and private manner. All eight residents interviewed were satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process, however this is not well evidenced in the family contact sheet or progress notes (link #1.1.9.1). The assessment tools link to the individual care plans. The care plans are individualised for each resident need such as (but not limited to): memory/behaviour/cognition, communication, mobility and safety, personal cares, continence and elimination, skin care, sleep and rest, pain management, nutrition, sexuality and intimacy, cultural and spiritual, respiratory function, and other clinical issues. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents' files include; resident information and family contact sheet, advanced directives and resuscitation status, the long term care plan, medical problem list and medical notes, activities social assessment, the diversional therapy plan, observations and weight charts, assessments, the initial assessment and care plan, three monthly review forms, short term care plans, needs assessments, lab forms, correspondence, incident summary, and infection summary.

The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The registered nurses have yet to complete the training for using the InterRAI assessment tool at Dixon House. Resident comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Eight residents and three family members interviewed stated they are involved in the care planning process. Seven of seven resident comprehensive long term care plans reviewed were evidenced to be up to date.

Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): memory/behaviour/cognition, communication, mobility and safety, personal cares, continence and elimination, skin care, sleep and rest, pain management, nutrition, sexuality and intimacy, cultural and spiritual, respiratory function, and other clinical issues. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. Improvement is needed in detailing interventions. Four of seven care plans recorded sufficient detail to guide care staff. Three of seven resident files reviewed did not record sufficient detail to guide care staff in behaviour issues and triggers, falls prevention and management or in regard to a postural drop. Activities care plans were completed for three of seven files reviewed. Four of seven activities plans were not completed. Improvements are required in these areas.

There is evidence that residents are seen by the GP at least three monthly.

The GP signs a form stating the resident is stable and for three monthly visits. Short term care plans examples sighted are cares required for infections. Improvement is needed to ensure STCPs are in place for all short term care issues.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The registered nurses have yet to complete the training for using the InterRAI assessment tool at Dixon House. Resident comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Eight residents and three family members interviewed stated they are involved in the care planning process. Seven of seven resident comprehensive long term care plans reviewed were evidenced to be up to date. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): memory/behaviour/cognition, communication, mobility and safety, personal cares, continence and elimination, skin care, sleep and rest, pain management, nutrition, sexuality and intimacy, cultural and spiritual, respiratory function, and other clinical issues. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. Improvement is needed in detailing interventions. Four of seven care plans recorded sufficient detail to guide care staff. Three of seven resident files reviewed did not record sufficient detail to guide care staff in behaviour issues and triggers, falls prevention and management or in regard to a postural drop. Activities care plans were completed for three of seven files reviewed. Four of seven activities plans were not completed. Improvements are required in these areas

**Finding:**

(i) Activities care plans were incomplete on four of seven resident files reviewed; (ii) STCPs were not in place for all short term care issues; (iii) one resident's care plan was not updated following a change from self-medicating; (iv) care plan interventions do not always record sufficient detail to guide care staff. These include one resident with behaviour issues and wandering, two with incidence of falls and one with postural drop.

**Corrective Action:**

(i) Ensure all residents have activities care plans completed in their clinical file; (ii) ensure interventions to manage acute needs are documented on a STCP or the LTCP is updated; (iii) ensure LTCP's are updated when there is a change in care needs prior to their scheduled review; (iv) ensure all care plan interventions are recorded in sufficient detail to guide care staff.

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Dixon House provides services for residents requiring rest home level of care. Individualised care plans are completed. The three caregivers and one registered nurse and one enrolled nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment.

Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

There are currently three wounds being treated and two recent healed pressure injuries being monitored. Wound assessment and management plan is completed for the three wounds (one scalp lesion, one leg ulcer and one vulval skin condition) and there was evidence of input from wound specialists district nurse and GP. Wound care education was provided to care staff in August 2014 and the EN has also attended external training relating to wound management in 2014.

Eight residents and three family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs.

Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.

There is one full time registered nurse and one part time registered nurse who provide RN cover over each day of the week. A record of all health practitioners practicing certificates is kept. Enrolled nurses are rostered on every shift.

Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. Improvements are required whereby weights are monitored at intervals as per resident requirements and policy and procedures. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents 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:** PA Low

**Evidence:**

Dixon House provides services for residents requiring rest home level of care. Individualized care plans are completed. The three caregivers and one registered nurse and one enrolled nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring equipment, and pressure relieving equipment. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools

which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.

**Finding:**

Policy states weight monitoring to be conducted monthly. Weights are currently undertaken three monthly. However, on review of seven resident files, it is noted that in four of seven files, this is not routinely conducted - with gaps of up to eight months.

**Corrective Action:**

Ensure all residents are weighed monthly or more frequently as required, and this recorded in their clinical file.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is one activities coordinator at Dixon House who is responsible for the planning and delivery of the activities programme with assistance from the manager and care staff. The activities coordinator works 1030-1600 Monday to Thursday. The activities coordinator has over eight years' experience working in aged care and has completed her diversional therapy qualification. Caregivers assist with activities during the week and at weekends. There are currently six residents who are assessed as rest home level care but who have diagnoses of varying degrees of dementia. The service receives extra funding for afternoon and evening activities which are provided by caregivers. Caregivers document on each shift what activities these residents have engaged in.

Activities are provided in the large communal lounge/dining room, in seating areas including a computer area, gardens (when weather permits) and one on one input in resident's rooms when required. On the days of audit residents were observed being actively involved with a variety of activities including story reading/discussions, church service and one on one input. The activities programme is developed monthly and a copy of the programme is available in the lounge, on noticeboards and in each resident room. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events.

The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this used to develop a diversional therapy plan which is then reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.

Dixon House has its own van for transportation. Residents interviewed described weekly van outings, music entertainment and attendance at a variety of community events. The activities coordinator has a current first aid certificate.

D16.5d: Resident files reviewed identified that four out of seven files did not include complete activity plans (link #1.3.5.2).

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> All initial care plans were developed by a registered nurse on day of admission and resident comprehensive long term care plans developed within three weeks of admission in seven of eight care plans reviewed (one respite). Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in seven of eight resident files sampled. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by a RN. GP's review residents three monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents. Short term care plans were evident for the care and treatment of infections (link #1.3.5.2).

**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.

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

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service facilitates access to other medical and non-medical services. The registered nurse interviewed confirms that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.

There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.

Dixon House uses the Webster Pack System of four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. An improvement is required whereby the GP records indications for use on PRN medications.

The medication folder includes a list of specimen signatures. 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) allergies and c) duplicate name. Education on medication management occurred in August and September 2014 with competencies conducted for registered and enrolled nurses and senior caregivers with medication administration responsibilities. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication.

The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents' medication charts and resident files on the front page. Fourteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Medications were safely stored on one medication trolley which is stored in the locked nurse's station when not in use. All medications were up to date and eye drops were dated on opening.

Controlled drugs stored securely in a locked safe in a locked cupboard. The controlled drug register showed evidence of weekly and six monthly checks. The register showed evidence of two signatures when signing out controlled drugs. One registered nurse was observed administering medications. It was noted that improvements are required in relation to checking of medication charts at the time of administration and following correct medication administration process.

**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:** PA Moderate

**Evidence:**

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP. Dixon House uses four weekly blister packs and verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. The medication folder includes a list of specimen signatures. 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) allergies and c) duplicate name.

**Finding:**

On review of 14 medication charts, it is noted that; (i) four of 14 charts do not record indications for use of PRN medication orders. All regular tablet medication is pre-packed by the pharmacy into blister packs. (ii) Out of normal time medications were given to residents without staff checking the medication chart. (iii) Correct procedure was not followed (observed) when administering medications two residents.

**Corrective Action:**

(i) Ensure that all medication orders are completed appropriately as per best practice. (ii) And (iii) Ensure policy and procedure is followed by care staff when administering medications

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

Dixon House has a fully equipped kitchen and all food is cooked on site. There are two cooks and two kitchen hands. D19.2: All kitchen staff have completed food safety training. The cook was working as a relieving cook on the days of audit. There is a four weekly rotating menu. The menu was reviewed by a dietitian in December 2013. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served hot directly from the oven and oven top from food preparation containers to residents in the dining room or to their rooms as required. A tray service is provided at breakfast time to residents in their rooms if required. All food in the freezer and fridge is labelled or dated.

The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook interviewed. Forms from the registered nurse to the kitchen were sighted for residents requiring special diets. The cook reports special diets being catered for include diabetic diets and soft diets. Weights are recorded routinely three monthly as directed by the registered nurse with exceptions (link #1.3.6.1). Residents report satisfaction with food choices, and meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks.

#### **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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.3.13.5 (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.

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

There are policies in place for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with three caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in February 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service displays a current building warrant of fitness which expired on 1 July 2014, the review and renewal for this is currently with the Grey District Council who are following through this process. Advised that the service is awaiting sign off from Wormald regarding the sprinkler system in an area at the rear of the building. Improvements are required in this area. The assessment for hot water temperatures checks are conducted and recorded monthly by the maintenance person. Hot water is provided via an electric hot water system which is set at 45 degrees for resident areas. Hot water temperature recordings reviewed for year to date 2014 are consistently recorded between 43 and 45 degrees Celsius. Medical equipment including hoist, chair scales, blood pressure machine and thermometer have been calibrated by an authorised technician. The interior is well maintained with a home-like décor and furnishings. The facility has a first floor area that can be accessed via a lift or either of two flights of stairs. Upstairs there are five resident rooms, a tea making area and offices. On the ground floor there is a large communal lounge and dining area, a chapel and small sitting areas. There are sufficient communal toilets adjacent to the lounge and dining areas. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is an external designated smoking area. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with three caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans

### **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 displays a current building warrant of fitness which expired on 1 July 2014, the review and renewal for this is currently with the Grey District Council who are following through this process. Advised that the service is awaiting sign off from Wormald regarding the sprinkler system in an area at the rear of the building.

**Finding:**

The service does not display a current building warrant of fitness. The building warrant of fitness expired on 1 July 2014

**Corrective Action:**

Provide evidence that the building a current building warrant of fitness and that this is displayed.

**Timeframe (days):** 60 (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 five single rooms upstairs and 35 downstairs in Dixon House which all have either a full ensuite or individual toilet and basin, there are also communal showers and toilets throughout the facility. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Eight residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.

Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs

#### **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:**

The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

There is a large lounge and dining room, a chapel and small seating areas. The dining room is spacious, located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Eight 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:**

Dixon House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer's data safety charts are available. Eight residents and three family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Laundry and cleaning audit conducted in July 2014 with corrective action completed.

**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 D15.3j; D19.6

**Attainment and Risk:** PA Low

**Evidence:**

Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies and procedures for civil defence and other emergencies. The service has an emergency civil defence box including torches and radios. Emergency lighting and a gas BBQ are available in the event of a power failure. A battery backup supplies power to the emergency lighting. Staff stated that there were plenty of spare blankets available also. The service has extra food and water supplies available for use in the event of an emergency. Call bells were evident in resident's rooms', lounge, and toilets/bathrooms. Call bells were observed to be answered appropriately on day of audit. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly fire drills are scheduled to occur however, these have not routinely been conducted. Improvements are required in this area. Fire training was provided in July 2014 and civil defence training was provided in June 2014. Security procedures are established. Contractors to Dixon House are required to identify themselves and sign visitor's book.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies and procedures for civil defence and other emergencies. The service has an emergency civil defence box including torches and radios. Emergency lighting and a gas BBQ are available in the event of a power failure. A battery backup supplies power to the emergency lighting. Staff stated that there were plenty of spare blankets available also. The service has extra food and water supplies available for use in the event of an emergency. Call bells were evident in resident's rooms', lounge, and toilets/bathrooms. Call bells were observed to be answered appropriately on days of audit. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly fire drills are scheduled to occur however, these have not routinely been conducted. Fire training was provided in July 2014 and civil defence training was provided in June 2014.

**Finding:**

Fire drills have not been conducted six monthly. Fire drills were conducted on 18 September 2013 and again on the 20 June 2014.

**Corrective Action:**

Conduct fire drills six monthly as per policy and fire safety training requirements. Next fire drill due prior to or on the 20 December 2014.

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

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

All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Eight residents and three family interviewed state the environment is warm and 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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Dixon House has comprehensive policies and procedures on restraint minimisation and safe practice. The quality manager/registered nurse is the restraint coordinator and confirms that the service promotes a restraint-free environment.

Policy states that enablers are voluntary. There are no residents using enablers and one resident recently assessed as requiring restraint. The restraint (bedrails) has been instigated as a falls prevention method in September 2014. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.

Documentation includes restraint register, restraint/enabler assessment forms, restraint consent forms, monitoring forms, and three-monthly evaluation forms. Restraint education was last provided for staff in September 2014. Challenging behaviour education was last provided in October 2014, and dementia care in May 2014.

#### **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:** PA Low

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the quality manager (RN). Restraint use is a regular agenda item in quality assurance/clinical meetings. Restraint use approval group is part of the quality assurance committee. Staff interviews confirm their understanding of using restraint only as a last resort, is not used for behaviour control and is used as a falls prevention measure and for resident safety and security. Education relating to restraint is provided and staff have completed restraint questionnaires. Prior to September 2014 the facility has been restraint free. One resident with restraint (bedrails) is recorded on the restraint register. Improvements are required whereby the GP is involved in the restraint approval process.

### **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:** PA Low

**Evidence:**

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes key responsibilities for the restraint coordinator, who is also the quality manager (RN). Restraint use is a regular agenda item in quality assurance/clinical meetings. Restraint use approval group is part of the quality assurance committee. Prior to September 2014 the facility has been restraint free. One resident with restraint (bedrails) is now recorded on the restraint register. Advised by the quality manager that the resident and family have been included in the restraint approval process and discussion around this.

**Finding:**

There is a lack of evidence in the resident file to confirm that the GP has been involved in the restraint approval process.

**Corrective Action:**

Provide evidence that the GP has been part of the restraint approval process.

**Timeframe (days):** 90 (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:** PA Low

**Evidence:**

Restraint documentation is provided as part of the restraint policies and procedures and includes a restraint assessment form. While the service has assessed the resident for the bedrails, the restraint assessment documentation has not been utilised. Improvements are required in this area. The quality manager and registered nurse have conducted the assessment in partnership with the resident and their family/whanau. Restraint consent form has been completed for the one resident requiring restraint.

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

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

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** PA Low

**Evidence:**

Restraint documentation is provided as part of the restraint policies and procedures and includes a restraint assessment form. The service has assessed the resident for the bedrails, however the restraint assessment documentation has not been utilised. The quality manager and registered nurse have conducted the assessment in partnership with the resident and their family/whanau. Restraint consent form has been completed for the one resident requiring restraint

**Finding:**

Restraint assessment documentation has not been completed for the one resident with restraint (bedrails).

**Corrective Action:**

Ensure that restraint assessment documentation is completed for all residents requiring restraint.

**Timeframe (days):** 90 (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:** PA Low

**Evidence:**

The quality manager/RN is the restraint co-ordinator. She receives advice and input from the resident's general practitioner and family/whanau.

The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service.

Approved restraints include lap belts and bedside rails.

One resident file with restraint was reviewed. The resident has bedrails in place when in bed and is used for the purpose of falls prevention. There is evidence that the resident's care plan includes reference to the restraint. Improvements are required whereby each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome. Restraint monitoring forms are available but have not been utilised.

One of one restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used.

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

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

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;

- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

One resident file with restraint was reviewed. The resident has bedrails in place when in bed and is used for the purpose of falls prevention. There is evidence that the resident's care plan includes reference to the restraint. Restraint monitoring forms are available but have not been utilised. One of one restraint files reviewed had a consent form detailing the reason for restraint and the restraint to be used

**Finding:**

Each episode of restraint has not been documented in sufficient detail to provide an accurate account of the indication for use, duration and the expected outcome.

**Corrective Action:**

Ensure that each episode of restraint is monitored and recorded.

**Timeframe (days):** 90 (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 restraint coordinator (quality manager/RN) advised that she will reassess the resident using restraint for their on-going restraint needs. The restraint coordinator monitors the review of safe restraint practice. A system of evaluation and review of restraint/enabler use is conducted via the quality assurance /clinical meeting. The resident on restraint will be reviewed at three monthly intervals (commenced September 2014). This review assesses the following: alternative strategies explored, desired outcome and whether it is being achieved, whether the restraint used is the least restrictive option, the duration of the restraint, the impact the restraint has on the resident, and were policies and procedures followed. Family/whanau participates in evaluations as required.

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

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator is responsible for ensuring restraint use is actively minimised, monitored and reviewed for each episode of restraint use. The service has introduced new restraint policies and procedures and associated documentation. The restraint programme is reviewed as part of the quality assurance/clinical meeting. Episodes of restraint/enabler use, are reviewed to ensure the restraint is only used when necessary, appropriate and safe.

### 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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Dixon House has an established infection control programme. The infection control coordinator is an enrolled nurse with support provided by the quality manager/registered nurse. There is a job description for the infection control coordinator's role. The IC programme is appropriate for the size, complexity, and degree of risk associated with the service and is linked into the incident reporting system. Infection control is a standing agenda item on the quality assurance/clinical meetings and at staff meetings. There is discussion and reporting of infection control surveillance and issues. Minutes are available for staff to read. The programme is reviewed annually.

## **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:**

An enrolled nurse at Dixon House is the nominated Infection control coordinator. She is supported by the registered nurses, quality manager and staff who make up the infection control committee, which consists of the quality team and includes registered nurses, activities staff, cook, care staff, and management. The infection control coordinator has expert external infection control specialist support from public hospital infection control nurse specialist, Med Lab and the facility GP's. The resources are adequate to implement the infection control programme for the size and complexity of the organisation.

### 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:**

Dixon House infection control policies include -role of infection prevention and control, epidemiology and surveillance; standard and transmission based precautions; isolation precautions; management of an outbreak of infection; employee health; cleaning, hand hygiene, standard precautions, transmission based precautions, employee health, management of an outbreak, reprocessing of medical instruments and equipment, waste management, single use items, antimicrobial usage and renovation and construction. New infection control policies were provided as part of the new quality management system implemented in November 2013. New policies have been introduced to staff with an acknowledgment form signed by staff on completion of reading.

#### **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:**

Infection control education is compulsory for all staff with results of surveillance activities and infection control audits providing the infection control coordinator with opportunities to improve practises. Infection control coordinator attends external education opportunities as they arise. The quality manager/RN is responsible for coordinating education and training to staff. The service has an orientation package which includes specific training around hand washing and standard precautions. Interviews with three caregivers confirmed that they have received education around infection control and this was evidenced in seven staff files reviewed. Education relating to disease prevention and observations, hand washing, scabies and norovirus has been provided in the past 12 months. The Infection control expert from the local hospital attends the service and conducts the education for staff. The quality manager/RN has completed an on-line infection prevention and control course.

#### 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:**

Surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (EN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP and community med lab that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There is an infection control register in which all infections are documented monthly and submitted to the quality/clinical committee and at the staff meetings. All infections are discussed and any trends identified with subsequent educational opportunities for improvement in practises if needs are identified.

Standard definitions for surveillance include definitions for wound infections, skin infections, urinary tract infections, eye/nose/mouth/ear, respiratory, and gastro. Surveillance on infections includes the resident name, infection type, organism if known, start and finish date, treatment and dosage, and outcome. The service also records any infections not requiring antimicrobial treatment.

#### **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.)