# Seadrome Limited

## Current Status: 18 November 2013

**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

Seadrome Home and Hospital provides residential care for up to 45 residents who require hospital or rest home level care. Occupancy on the day of the audit was at 44. No changes to the facility or management have occurred since the last audit.

This certification audit was undertaken to monitor compliance with all parts of the Health and Disability Services Standard and the aged care contract. Sixteen areas requiring improvement have been identified at this audit. Low risk issues relate to on-going staff education as required by the aged care contract, maintenance of health and safety checks, recording of all events in residents’ progress notes, records and monitoring of short term interventions, management of waste and hazardous substances, transport protocols, ventilation in one shower and heating in showers. Moderate risk issues relate to orientation of new staff to the needs of dementia residents and response to clinical emergency, maintenance of functional and electrical safety checks of equipment, call bell system in the rest home, safety gate on external stairs, clinical emergency protocols, maintenance of medication administration records and records of adverse events.

Three best practice projects that have resulted in achievement and maintenance of improved outcomes for residents have been recognized with a Continuous Improvement rating.

## Audit Summary as at 18 November 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 18 November 2013

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

### Organisational Management as at 18 November 2013

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

### Continuum of Service Delivery as at 18 November 2013

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| --- | --- | --- |
| 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. |

### Safe and Appropriate Environment as at 18 November 2013

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| --- | --- | --- |
| 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 medium or high risk and/or unattained and of low risk. |

### Restraint Minimisation and Safe Practice as at 18 November 2013

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

### Infection Prevention and Control as at 18 November 2013

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

## Audit Results as at 18 November 2013

### Consumer Rights

Residents' rights are understood and met in everyday practice. Information is provided to residents and families in a timely manner, they are treated with dignity and respect, their privacy is preserved and they are free from discrimination. Training relating to resident's rights, professional boundaries, privacy and dignity and freedom from harassment has been provided to staff in the last two years.

There is adequate access to cultural advice, resources and documented protocols to ensure recognition of Maori values and beliefs for residents who identify as Maori. Communication channels are clearly defined and interviews and observation confirm communication effectiveness with open disclosure of adverse events to residents and families. The manager has an open door policy for relatives and meets with residents monthly. Resident and family interviews and meeting minutes confirm that residents’ concerns are attended to promptly.

Informed consent requirements are clearly documented. Choice is given and records maintained. A system for advanced directives is maintained. Enduring Power of Attorney orders are in place. Links with community resources are supported and facilitated. Advocacy information is freely available and resident interviews confirm understanding of their right to make complaints if necessary. The complaints process meets the requirements of the Health and Disability Consumers Code of Rights. An improvement is required to ensure that all complaints and concerns are entered in the complaints register. There have been no investigations by the Health and Disability Commissioner, the District Health Board or ACC. Relevant aged care contract requirements are met

### Organisational Management

The facility is managed by a registered psychiatric nurse with post graduate qualifications in group therapy, geriatric nursing and personnel management. The manager has extensive experience in the care of older people and in facility management and maintains more than thirty hours of on-going education each year. There is an experienced registered nurse who deputises in the absence of the manager.

Quality and risk management systems are appropriate for the services provided. Quality and risk management requirements are included in staff orientation and staff meetings. The quality plan and goals are reviewed annually. Quality data is collected and analysed monthly by the manager and registered nurses and reviewed at monthly quality meetings. Up to date documented service delivery policies and procedures are available to staff in their work areas.

There are implemented risk management and health and safety policies and procedures in place including incident, accident and hazard management. There are processes in place for recording adverse events including taking appropriate actions to prevent recurrence. Incidence and trends are monitored and addressed as required. Improvement is required to ensure that medication discrepancies are documented in the adverse events management records. Families are notified of any issues promptly. Improvement is required to ensure that guidelines for statutory reporting requirements are identified.

There is a hazard management reporting system and the facility hazard register is reviewed and updated as hazards are identified.

Resident records are maintained up to date and securely stored. Improvement is required to ensure that all events are documented in the resident’s progress notes.

Documented employment processes comply with good employment practice. Qualifications are verified for all new staff. A documented staff orientation programme that includes an introduction to dementia care is in place. Improvement is required to ensure that individual records of orientation are maintained for all new staff, and that the programme includes all elements required by the aged care contract including implementation of activities and therapies for residents with dementia, and response to relevant clinical emergencies. Improvement is also required to ensure that a documented orientation is implemented and recorded with bureau staff prior to commencing their shift.

Relevant ongoing training is provided monthly for all staff. All RNs have completed training in relation to the care of people with dementia. All staff attend fire training and trial evacuation training at least annually. Improvement is required to ensure that all staff attend the abuse and neglect training, and that manual handling and competency with hoists is reviewed annually with all staff, An annual performance appraisal system is maintained.

Twenty four hour registered nurse cover is provided with further back up from the manager and experienced registered nurses after hours. Staff numbers and skill mix meet contractual requirements and are adequate for the number and dependency of residents and the layout of the facility over the 24 hours. At least one registered nurse is on duty on each shift with experienced advice and assistance on back up at all times.

### Continuum of Service Delivery

There is a clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the services provided are made available. The admission pack includes eligibility criteria and required entry information.

Care and support is provided by a range of health professionals. This includes the registered nurse, trained caregivers, general practitioners and visiting allied health professionals. Clear time frames for service provision are defined and monitored.

Assessments and care plans are documented. Interventions are consistent with good practice in both dementia and hospital level care. Care planning is consistent and includes the required domains; however an improvement is required to ensure that all relevant interventions are cross referenced within the care plan. Care plans are reviewed in a timely manner. Short term care plans are documented on entry; however there is an additional opportunity for improvement with regard to recording short term care needs in a consistent and sufficient manner.

Residents maintain access to a range of health services. Referrals and transfers are managed in the timely and appropriate manner. Records of referrals and transfers are maintained and there is evidence that family are involved.

Individual activities are planned to meet the needs of the resident and are culturally appropriate. Activities are provided in a manner that is meaningful and with a goal to maintaining a sense of self, safety and increased engagement/enjoyment with the environment. The completion of a recent research project on sensory deprivation in people with dementia has demonstrated improved outcomes for participating residents.

Seadrome has the required documented systems in place to safely manage medications, however an improvement is required to ensure that all medications are administered (and recorded) as required. All medications are stored securely and are monitored by the registered nurses and the GP. Administration is conducted by staff that have completed a medication competency.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietitian. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements, however there is an opportunity for improvement regarding maintaining evidence of temperature monitoring.

### Safe and Appropriate Environment

Services are provided from a facility that accommodates the rest home and hospital in two interconnected wings.

There is a planned maintenance programme and the facility is well maintained. Improvement is required to ensure that minor superficial maintenance in two showers and a bedroom is attended to promptly. Furnishings are sufficient and suitable for the care and support of elderly, dependent residents. Applicable building regulations and requirements are met. Sufficient equipment and supplies are provided to meet the care needs of the residents. Improvement is required to ensure that all items of equipment and appliances requiring functional testing, electrical tests or calibration are identified and appropriate checks are maintained. Large, well-furnished lounge, and dining areas are provided in the rest home and the hospital with additional small sitting areas. Telephones and mail services are readily available. All areas of the facility have natural light and are maintained at a comfortable temperature for the residents. Improvement is required to provide some form of heating in the residents’ showers.

Bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. There is a call bell in every room. Call bells in the rest home area do not have pull cords. Improvement is required to ensure that alternative risk management processes are in place to ensure that staff become aware of and respond to residents need for assistance promptly. Toilet, shower and bathing facilities are sufficient and appropriately equipped and fitted out for the number and dependence of the residents. Hot water temperatures in resident areas are maintained within safe parameters.

The facility is clean and fresh. Cleaning processes meet infection control requirements. Staff follow safe procedures when handling hazardous chemicals. Improvement is required to ensure that a hazardous substances register is documented and maintained, the oxygen bottles in the treatment room are restrained from falling over, and the credentials of the gasfitter are available on site. Laundry services are provided on site in an area that is fit for purpose. Laundry processes meet good practice guidelines. Collection and disposal of waste is in accord with infection control principles and complies with local body requirements. Improvement is required to ensure that the credentials of the waste disposal contractor are available, and that rubbish bins stored in an area that is accessible to wandering residents do not overflow and are secured from access. Steps have been taken to lock the rubbish bins, and an extra collection was done during the audit.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. All staff have current first aid skills and receive training in handling emergencies and evacuation. Improvement is required to ensure that all staff attend a trial evacuation annually.

Enclosed gardens and safe, sheltered external areas are available for the use of residents in the rest home and hospital. A separate, sheltered area is provided for use by smokers. The deck outside the rest home unit has safety balustrades but there is an unguarded set of stairs leading down into the garden. Improvement is required to ensure that a suitable safety gate is installed to prevent falls down the stairs. There are paved pathways for residents to walk in the grounds. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit onto the road.

Residents are transported to external appointments and events in a car with current registration and warrant of fitness. Imrpovement is required to ensure that the currency of drivers’ licence is maintained and that there are guidelines for passenger numbers, escorts and use of seat belts.

### Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints and enablers and managing behaviours of concern. Seadrome actively minimises the use of restraints and there are no restraints or enablers is use. All staff receive training on restraint, enabler and managing behaviours of concerns. Staff are observed as proficient in ensuring all residents remain safe and calm.

### Infection Prevention and Control

The infection control policy is clearly documented and is suitable for the facility. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. External expert advice is sought to ensure that infection prevention and control processes are up to date. Infection control is included in health and safety, quality and risk management, and emergency systems.

The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and infection control data is communicated amongst staff and management. The facility maintains relatively low numbers of infections.

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **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**

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| **Legal entity name:** | Seadrome Ltd. |
| **Certificate name:** | Seadrome Home & Hospital |

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| **Designated Auditing Agency:** | Health Audit NZ Ltd. |

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| **Types of audit:** | Certification | | | |
| **Premises audited:** | 167 Colwill Rd, Massey, Auckland | | | |
| **Services audited:** | Geriatric Services, Dedicated Dementia Care | | | |
| **Dates of audit:** | **Start date:** | 18 November 2013 | **End date:** | 19 November 2013 |

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| **Proposed changes to current services (if any):** |
| None |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 44 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 19 | Total audit hours | 43 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 2 | Number of staff interviewed | 12 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 26 November 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Seadrome Home and Hospital provides residential care for up to 45 residents who require hospital or rest home level care. Occupancy on the day of the audit was at 44. No changes to the facility or management have occurred since the last audit.  This certification audit was undertaken to monitor compliance with all parts of the Health and Disability Services Standard and the aged care contract. Sixteen areas requiring improvement have been identified at this audit. Low risk issues relate to on-going staff education as required by the aged care contract, maintenance of health and safety checks, recording of all events in residents’ progress notes, records and monitoring of short term interventions, management of waste and hazardous substances, transport protocols, ventilation in one shower and heating in showers. Moderate risk issues relate to orientation of new staff to the needs of dementia residents and response to clinical emergency, maintenance of functional and electrical safety checks of equipment, call bell system in the rest home, safety gate on external stairs, clinical emergency protocols, maintenance of medication administration records and records of adverse events.  Three best practice projects that have resulted in achievement and maintenance of improved outcomes for residents have been recognized with a Continuous Improvement rating. |

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| **Outcome 1.1: Consumer Rights** |
| Residents' rights are understood and met in everyday practice. Information is provided to residents and families in a timely manner, they are treated with dignity and respect, their privacy is preserved and they are free from discrimination. Training relating to resident's rights, professional boundaries, privacy and dignity and freedom from harassment has been provided to staff in the last two years.  There is adequate access to cultural advice, resources and documented protocols to ensure recognition of Maori values and beliefs for residents who identify as Maori. Communication channels are clearly defined and interviews and observation confirm communication effectiveness with open disclosure of adverse events to residents and families. The manager has an open door policy for relatives and meets with residents monthly. Resident and family interviews and meeting minutes confirm that residents’ concerns are attended to promptly. Informed consent requirements are clearly documented. Choice is given and records maintained. A system for advanced directives is maintained. Enduring Power of Attorney orders are in place. Links with community resources are supported and facilitated. Advocacy information is freely available and resident interviews confirm understanding of their right to make complaints if necessary. The complaints process meets the requirements of the Health and Disability Consumers Code of Rights. An improvement is required to ensure that all complaints and concerns are entered in the complaints register. There have been no investigations by the Health and Disability Commissioner, the District Health Board or ACC. Relevant aged care contract requirements are met |

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| **Outcome 1.2: Organisational Management** |
| The facility is managed by a registered psychiatric nurse with post graduate qualifications in group therapy, geriatric nursing and personnel management. The manager has extensive experience in the care of older people and in facility management and maintains more than thirty hours of on-going education each year. There is an experienced registered nurse who deputises in the absence of the manager.   Quality and risk management systems are appropriate for the services provided. Quality and risk management requirements are included in staff orientation and staff meetings. The quality plan and goals are reviewed annually. Quality data is collected and analysed monthly by the manager and registered nurses and reviewed at monthly quality meetings. Up to date documented service delivery policies and procedures are available to staff in their work areas.   There are implemented risk management and health and safety policies and procedures in place including incident, accident and hazard management. There are processes in place for recording adverse events including taking appropriate actions to prevent recurrence. Incidence and trends are monitored and addressed as required. Improvement is required to ensure that medication discrepancies are documented in the adverse events management records. Families are notified of any issues promptly. Improvement is required to ensure that guidelines for statutory reporting requirements are identified.  There is a hazard management reporting system and the facility hazard register is reviewed and updated as hazards are identified.  Resident records are maintained up to date and securely stored. Improvement is required to ensure that all events are documented in the resident’s progress notes. Documented employment processes comply with good employment practice. Qualifications are verified for all new staff. A documented staff orientation programme that includes an introduction to dementia care is in place. Improvement is required to ensure that individual records of orientation are maintained for all new staff, and that the programme includes all elements required by the aged care contract including implementation of activities and therapies for residents with dementia, and response to relevant clinical emergencies. Improvement is also required to ensure that a documented orientation is implemented and recorded with bureau staff prior to commencing their shift.   Relevant ongoing training is provided monthly for all staff. All RNs have completed training in relation to the care of people with dementia. All staff attend fire training and trial evacuation training at least annually. Improvement is required to ensure that all staff attend the abuse and neglect training, and that manual handling and competency with hoists is reviewed annually with all staff, An annual performance appraisal system is maintained.  Twenty four hour registered nurse cover is provided with further back up from the manager and experienced registered nurses after hours. Staff numbers and skill mix meet contractual requirements and are adequate for the number and dependency of residents and the layout of the facility over the 24 hours. At least one registered nurse is on duty on each shift with experienced advice and assistance on back up at all times. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| There is a clearly documented process for entry to the facility. Admissions are managed in an equitable and timely manner. Adequate information about the services provided is made available. The admission pack includes eligibility criteria and required entry information.   Care and support is provided by a range of health professionals. This includes the registered nurse, trained caregivers, general practitioners and visiting allied health professionals. Clear time frames for service provision are defined and monitored.   Assessments and care plans are documented. Interventions are consistent with good practice in both dementia and hospital level care. Care planning is consistent and includes the required domains; however an improvement is required to ensure that all relevant interventions are cross referenced within the care plan. Care plans are reviewed in a timely manner. Short term care plans are documented on entry; however there is an additional opportunity for improvement with regard to recording short term care needs in a consistent and sufficient manner.  Residents maintain access to a range of health services. Referrals and transfers are managed in the timely and appropriate manner. Records of referrals and transfers are maintained and there is evidence that family are involved.   Individual activities are planned to meet the needs of the resident and are culturally appropriate. Activities are provided in a manner that is meaningful and with a goal to maintaining a sense of self, safety and increased engagement/enjoyment with the environment. The completion of a recent research project on sensory deprivation in people with dementia has demonstrated improved outcomes for participating residents.  Seadrome has the required documented systems in place to safely manage medications, however an improvement is required to ensure that all medications are administered (and recorded) as required. All medications are stored securely and are monitored by the registered nurses and the GP. Administration is conducted by staff that have completed a medication competency.   Food and nutritional needs of residents are assessed and the menu is reviewed by a dietitian. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements, however there is an opportunity for improvement regarding maintaining evidence of temperature monitoring. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Services are provided from a facility that accommodates the rest home and hospital in two interconnected wings..  There is a planned maintenance programme and the facility is well maintained. Improvement is required to ensure that minor superficial maintenance in two showers and a bedroom is attended to promptly. Furnishings are sufficient and suitable for the care and support of elderly, dependent residents. Applicable building regulations and requirements are met. Sufficient equipment and supplies are provided to meet the care needs of the residents. Improvement is required to ensure that all items of equipment and appliances requiring functional testing, electrical tests or calibration are identified and appropriate checks are maintained. Large, well-furnished lounge, and dining areas are provided in the rest home and the hospital with additional small sitting areas. Telephones and mail services are readily available. All areas of the facility have natural light and are maintained at a comfortable temperature for the residents. Improvement is required to provide some form of heating in the residents’ showers.  Bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. There is a call bell in every room. Call bells in the rest home area do not have pull cords. Improvement is required to ensure that alternative risk management processes are in place to ensure that staff become aware of and respond to residents need for assistance promptly. Toilet, shower and bathing facilities are sufficient and appropriately equipped and fitted out for the number and dependence of the residents. Hot water temperatures in resident areas are maintained within safe parameters.   The facility is clean and fresh. Cleaning processes meet infection control requirements. Staff follow safe procedures when handling hazardous chemicals. Improvement is required to ensure that a hazardous substances register is documented and maintained, the oxygen bottles in the treatment room are restrained from falling over, and the credentials of the gasfitter are available on site. Laundry services are provided on site in an area that is fit for purpose. Laundry processes meet good practice guidelines. Collection and disposal of waste is in accord with infection control principles and complies with local body requirements. Improvement is required to ensure that the credentials of the waste disposal contractor are available, and that rubbish bins stored in an area that is accessible to wandering residents do not overflow and are secured from access. Steps have been taken to lock the rubbish bins, and an extra collection was done during the audit.   Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. All staff have current first aid skills and receive training in handling emergencies and evacuation. Improvement is required to ensure that all staff attend a trial evacuation annually.  Enclosed gardens and safe, sheltered external areas are available for the use of residents in the rest home and hospital. A separate, sheltered area is provided for use by smokers. The deck outside the rest home unit has safety balustrades but there is an unguarded set of stairs leading down into the garden. Improvement is required to ensure that a suitable safety gate is installed to prevent falls down the stairs. There are paved pathways for residents to walk in the grounds. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit onto the road.  Residents are transported to external appointments and events in a car with current registration and warrant of fitness. Imrpovement is required to ensure that the currency of drivers’ licence is maintained and that there are guidelines for passenger numbers, escorts and use of seat belts. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are adequately documented guidelines on the use of restraints and enablers and managing behaviours of concern. Seadrome actively minimises the use of restraints and there are no restraints or enablers is use. All staff receive training on restraint, enabler and managing behaviours of concerns. Staff are observed as proficient in ensuring all residents remain safe and calm. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control policy is clearly documented and is suitable for the facility. Infection control responsibilities are clearly documented. Adequate information, resources and on-going training are provided. External expert advice is sought to ensure that infection prevention and control processes are up to date. Infection control is included in health and safety, quality and risk management, and emergency systems.  The infection surveillance program is appropriate for the facility and the level of care provided. Use of antibiotics is monitored and infection control data is communicated amongst staff and management. The facility maintains relatively low numbers of infections. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 30 | 0 | 10 | 3 | 0 | 0 |
| **Criteria** | 1 | 76 | 0 | 12 | 4 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Verbal complaints documented in complaints and concerns books in the rest home and the hospital are not entered in the complaints register. | Ensure that all concerns and complaints are entered in the complaints register. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.9 | 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. | PA Low | Six monthly health and safety checks have not been carried out against the hazard register in the last 12 months. | Ensure that the six monthly hazard control checks are consistently maintained. | 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 | Not all adverse events are documented in the adverse events system, for example medication omissions and errors. | Ensure that medication errors and omissions are documented in the adverse events records system. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | 1. The orientation programme does not include clinical emergency protocols nor implementation of activities and therapies for residents with dementia as required by the ARC. 2. Orientation records are not consistently maintained for all staff, for example, for three of five staff employed in the last 12 months, and for bureau staff. | 1. Revise the orientation programme to include clinical emergency protocols and implementation of activities and therapies for residents with dementia. Update all current staff. 2. Maintain orientation records in staff files. | 90 |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Not all staff have completed required training or competency verifications in relation to abuse and neglect education, manual handling and use of hoists. | Ensure that all staff complete education and training in relation to abuse and neglect, manual handling, and competency using hoists | 90 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.1 | Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Not all progress notes have been sufficiently documented to describe the current care and/or health needs of hospital residents. Examples include following an incident or admission to the hospital following transfer. | Maintain progress notes for all events. | 30 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.5.2 | Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Not all care plans make reference to the additional monitoring requirements | Cross reference the use of additional monitoring charts in the care plan. | 180 |
| 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 | Not all short term interventions have been recorded and/or monitored in the hospital. For example treatment during a urinary tract infection or maintaining fluid intake/output records. | Record and monitor all short term interventions. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Medication administration has not been consistently maintained. For example there are unexplained gaps in four out of seven administration records sampled in the hospital and one resident had not been consistently receiving their mid-day medication. | Provide evidence that administration is consistently maintained for residents in the hospital wing. | 90 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Temperature monitoring of the chiller/freezer have not been maintained. | Maintain temperature monitoring requirements in the kitchen. | 180 |
| HDS(C)S.2008 | Standard 1.4.1: Management Of Waste And Hazardous Substances | Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | 1. Processes for managing hazardous substances are not applied in the following situations - • A hazardous substance register is not maintained. • Two oxygen bottles stored in the treatment room are not restrained. • The credentials of the gas fitter who maintains the gas delivery system are not available.  2. Processes for managing waste are not consistently applied.  • Rubbish bins stored in an area that is accessible to wanderers are over full and not secured.  • The credentials of the waste contractor are not available. | 1. Consistently implement the following processes for managing hazardous substances and waste –  • Develop and maintain a hazardous substance register. • The oxygen bottles have been chained to the wall, No further action required. • Acquire and maintain a copy of the gas fitters credentials on file.  • Acquire and maintain a copy of the waste removal contractor’s credentials on file. • It is noted that the bins have been emptied and arrangement made to increase clearance to three times a week. The bins are now secured with a padlock. No further action required. | 90 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Moderate | The system for ensuring that equipment used in service delivery is maintained in a safe condition is not consistently implemented -  • There is no list identifying equipment requiring functional, electrical or calibration checks. • There is no process in place to ensure that all items of electrical equipment are maintained in a safe condition. • There is no process in place to calibrate the digital thermometers or the sphygmomanometers. • The credentials of the service person maintaining the hoists are not available  Repairs are not consistently maintained in all areas. For example – • Broken light switch in a bathroom • Hole in a bedroom wall. • Chipped and worn paintwork in a shower room. | Consistently implement all processes in relation to management of equipment - • List and identify all equipment requiring functional, electrical or calibration checks. • Develop and implement a process to ensure that all items of electrical equipment are maintained in a safe condition. • Develop and implement a process to calibrate the digital thermometers or the sphygmomanometers. • Obtain and maintain a copy of the credentials of the serviceperson maintaining the hoists.  Undertake repairs in relation to – • Broken light switch in bathroom 26 • Hole in the wall of bedroom27. • Chipped and worn paintwork in shower room 21. | 90 |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | There is no safety gate to prevent residents from falling down a short flight of steps leading down from the deck outside the dementia rest home unit to the garden.  Transport processes are not sufficiently defined in relation to guidelines for resident numbers, escorts and use of seat belts when residents are transported in the car. | Install a safety gate to prevent unattended residents falling down the stairs from the deck to the garden.  Clearly define guidelines in the transport policy for resident numbers, escorts and use of seat belts | 30 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.1 | Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Systems to manage emergencies do not include – 1. Protocols for and staff training for management of relevant clinical emergencies. 2. CPR and first aid training for all care givers.  4. Business continuity plan for maintaining safety of residents in a major utility outage or a civil emergency.  Transport processes for trips out in the car are not sufficiently defined in relation to guidelines for resident numbers, escorts and use of seat belts | 1. Develop protocols and train staff in relation to relevant clinical emergencies 2. Ensure that all staff have CPR/first aid training. 3. Develop a continuity plan for maintaining safety of residents in a major utility outage or a civil emergency.  Define guidelines resident numbers, escorts and use of seat belts when transporting residents in the car. | 60 |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Low | There is no emergency call function in the call bell system and no other emergency call has been identified or implemented.. There is no risk management plan in place to identify and coordinate the measures that have been put in place to ensure that residents in the rest home receive prompt assistance as required. | Identify and implement an emergency call system.  Identify and document the strategies put in place to ensure that residents in rest home bedrooms receive prompt assistance as required. | 7 |
| HDS(C)S.2008 | Standard 1.4.8: Natural Light, Ventilation, And Heating | Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.8.1 | Areas used by consumers and service providers are ventilated and heated appropriately. | PA Low | The ventilation fan in a shower with no window does not work. There is no means of heating the shower rooms. | Repair the fan in shower 25. Provide means of heating in the shower rooms. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.8: Good Practice | Consumers receive services of an appropriate standard. | CI |  |
| HDS(C)S.2008 | Criterion 1.1.8.1 | The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Seadrome Home and Hospital has implemented a number of innovations to improve outcomes for residents. These include the use of Health Passports and commencing a shared project with a local secondary school with an aim to better meeting residents’ cultural needs and improved social interaction. The project group has met and will involve Maori language students working one to one with individual residents. A project to improve the desirable responses in residents with dementia was commenced in 2010 and completed in 2013. The project was developed with the help of an occupational therapist and involved the provision of sensory based activities. Sensory deprivation is shown to have a negative effect specifically in people with dementia and the project was aimed at improving meaningful engagement/interactions with residents. Five of the most challenging and non-engaging residents were participants and the sensory based activity programme was consistently implemented and supported by all staff. Outcome measures were based on desirable and undesirable responses pre, during and post activities. The results have been analysed and demonstrate a desirable response in 31 out of 35 events during and after activities. The Manager reports that the residents are more actively engaged in their surroundings and responding better to staff and the environment. The research project, methodology and results are being presented at the 2013 Dementia Research Conference. |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented policies reflect the intent of the Code of Rights. The Code is included in the orientation of all new staff. Training related to various elements of the Code is provided for staff at least two yearly. Interviews with staff, residents and relatives, and observation during the audit in each area of the facility indicate that staff understand resident rights and their responsibilities, and that residents rights are observed in practice. ARC requirements are met |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented procedures and interviews with residents, families and staff together with observation confirm that residents' rights are understood and met in everyday practice. Information about the Code of Rights, advocacy services and the complaints process is provided in the admission pack, discussed by the manager or the registered nurse (RN) on admission and displayed in the entry foyer. The Code is displayed in Maori and English. Residents and families interviewed are aware of their rights and confirm that information is provided to them during the admission process. There is evidence that advocacy services have been successfully involved in supporting a resident. ARC requirements are met |

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

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

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

##### **Criterion 1.1.2.4 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequately documented procedures to ensure residents are provided with services that support their independence (where applicable) and maintain their privacy and dignity. A review of care plans confirms that personal and privacy needs are considered and documented where required. Residents' visual and auditory privacy is respected. A tour of the facility confirms that all residents have a private room. The majority of rooms contain personal belongings and family interviewed state the belongings are respected. Each bedroom door has the name of resident and a picture which provides meaningful insight into the person. On the day of the audit a shower curtain is missing, however this is replaced immediately. Interviews and observations confirm that Seadrome is committed to ensuring residents are not subjected to abuse or neglect. The different types of abuse and neglect are defined within policies and guidelines. Reporting requirements, management of investigations, and follow up activities are also defined. Management responds to all concerns in an appropriate and timely manner. Family members interviewed state they feel their family member is safe and treated with dignity and respect at all times. Relevant ARC requirements are met. |

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

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

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

##### **Criterion 1.1.3.2 (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.

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

##### **Criterion 1.1.3.6 (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.

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

##### **Criterion 1.1.3.7 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A Maori health plan is in place. There is adequate access to cultural advice, resources and documented protocols to ensure recognition of Maori values and beliefs for residents who identify as Maori. A caregiver assists the one resident of Maori ethnicity to the visit the local marae each week. A Maori adviser from the local DHB is available. Cultural safety training has been provided in the last two years. There are facilities for whanau to bring in Maori foods and to stay overnight with a dying relative should these be required. The facility is currently providing work experience for Maori high school students. Relevant ARC requirements are met. |

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

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

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

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

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

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

##### **Criterion 1.1.4.5 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is evidence in seven of seven resident files sampled that residents and family participate in identifying the resident's culture, values and beliefs on admission and that these are incorporated into care and activity plans as relevant. Interviews with residents and family members from each area and observation during the audit confirm that individual wishes are respected where practicable. Relevant ARC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation with specific reference to the needs or residents with dementia. All staff have a criminal record check and reference checks prior to employment. Staff receive information and education during orientation and on-going education about professional boundaries and non-discriminatory attitudes at least two yearly. Eleven of 11 staff interviewed are aware of facility policy forbidding staff from accepting gifts from residents or families, or from developing personal relationships. Interviews with residents and staff, and observation during the audit, indicate that residents are free of any form of coercion or discrimination.  Relevant ARC requirements are met . |

##### **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.

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

#### 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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Services provided at Seadrome Home and Hospital reflect current best practice in dementia care and continual improvement in terms of improving outcomes for residents.  There is a suite of documented procedures and guidelines that are suitable for the level and complexity of aged care services provided and include relevant good practice sources and references indicating that resident care is based on good practice principles. Relevant health strategies are referenced in policies and are consistent with national standards for dementia care. Quality team and staff meeting minutes, and six of six staff interviews confirm that staff meet monthly to discuss clinical practice and resident care issues. Staff attend external seminars and bring back current information. The facility manager accesses the internet for current research. The Manager also maintains contact with the MHSOP psychiatrist and attends monthly supervision with the Northern Regional Dementia Behaviour Support and Advisory Coordinator. The nursing process is used for all assessments, care planning and evaluations. Assessment and care planning tools sighted reflect good practice and clinical policies and procedures are developed and reviewed by registered nurses. Management and the majority of nurses have either completed InterRAI training or are in the process of doing so. Management ensures the required policies, procedures, guidelines and work instructions are documented and quality is monitored through sufficient quality and risk processes. Clinical risk is identified and monitored and adequate equipment and products (including wound and continence products) are provided. A number of residents in the hospital area are unable to walk or stand. Many residents demonstrate behaviour of concern. Seadrome has no reported restraint or enabler use and, at the time of the audit, there are no residents with wounds or pressure areas. Challenging behaviours are well managed and staff are observed using well applied techniques in the management of behaviour. The environment is calm and conducive to the safe care of residents with dementia There are adequate numbers of sufficiently trained staff on duty at all times. Services are overseen by an experienced manager who has worked in dementia care for a number of years. The manager demonstrates a comprehensive understanding of the care and support needs of people with dementia. The doctor interviewed states that appropriate interventions are implemented for the management and treatment of all health care needs and behavioural needs. A number of best practice and quality improvement innovations have been implemented with evidence of improved outcomes for residents. These include but are not limited to a project that has resulted in improving meaningful engagement/interactions with residents, the findings of which are to be presented at the 2013 Dementia Research Conference, participation in the HDC health passport project improving management of residents transitioning between rest home and hospital; and a shared project with Maori students from a local secondary school with an aim to better meeting residents’ cultural needs and improved social interaction.  Relevant ARC requirements are met. |

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

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

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| **Attainment and Risk:** CI |
| **Evidence:** |
| Seadrome has provided a number of examples of where best practice initiatives have resulted in improved outcomes for residents.  Seadrome Home and Hospital has implemented a number of innovations to improve outcomes for residents. These include the use of Health Passports and commencing a shared project with a local secondary school with an aim to better meeting residents’ cultural needs and improved social interaction. The project group has met and will involve Maori language students working one to one with individual residents. A project to improve the desirable responses in residents with dementia was commenced in 2010 and completed in 2013. The project was developed with the help of an occupational therapist and involved the provision of sensory based activities. Sensory deprivation is shown to have a negative effect specifically in people with dementia and the project was aimed at improving meaningful engagement/interactions with residents. Five of the most challenging and non-engaging residents were participants and the sensory based activity programme was consistently implemented and supported by all staff. Outcome measures were based on desirable and undesirable responses pre, during and post activities. The results have been analysed and demonstrate a desirable response in 31 out of 35 events during and after activities. The Manager reports that the residents are more actively engaged in their surroundings and responding better to staff and the environment. The research project, methodology and results are being presented at the 2013 Dementia Research Conference. |
| **Finding:** |
| Seadrome Home and Hospital has implemented a number of innovations to improve outcomes for residents. These include the use of Health Passports and commencing a shared project with a local secondary school with an aim to better meeting residents’ cultural needs and improved social interaction. The project group has met and will involve Maori language students working one to one with individual residents. A project to improve the desirable responses in residents with dementia was commenced in 2010 and completed in 2013. The project was developed with the help of an occupational therapist and involved the provision of sensory based activities. Sensory deprivation is shown to have a negative effect specifically in people with dementia and the project was aimed at improving meaningful engagement/interactions with residents. Five of the most challenging and non-engaging residents were participants and the sensory based activity programme was consistently implemented and supported by all staff. Outcome measures were based on desirable and undesirable responses pre, during and post activities. The results have been analysed and demonstrate a desirable response in 31 out of 35 events during and after activities. The Manager reports that the residents are more actively engaged in their surroundings and responding better to staff and the environment. The research project, methodology and results are being presented at the 2013 Dementia Research Conference. |
| **Corrective Action:** |
| Maintain continuous improvement outcomes |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Communication channels are clearly defined. Interviews with staff, residents and families, communication logs in resident records and observation confirm communication effectiveness with open disclosure of adverse events to residents and families. All staff wear clearly readable name badges. Resident meetings occur monthly and the manager has an open-door policy. Resident and family surveys are conducted each year and any issues raised are followed up and remedied promptly. Family members interviewed state they have the opportunity to talk to management or staff and are able to request changes if needed. The family members also state that they are contacted if there are changes in a resident's health status. There is a portable phone for resident use and residents may install a phone in their bedroom if they wish. Residents' mail is posted daily and personal mail is delivered daily to residents.  Relevant ARC requirements are met |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An informed consent policy is clearly documented and in accord with the right 10 of the Code of Health and Disability Services Consumers' Rights. The situations where general written consent is required are defined and include outings, photos, treatments, and sharing of information with other health professionals.  Residents' records and interviews with family members confirm that residents receive appropriate information. The required consents forms are sighted in  seven out of seven records sampled. A system for advanced directives is defined and maintained in compliance with regulatory requirements. All relatives are given information on advance directives and there is a system which allows for the identification of competency and resuscitation status. Enduring Power of Attorney orders are in place for those residents who need them. Relevant ARC requirements are met. |

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

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

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

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

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

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

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented advocacy policy that details Health and Disability Commission and Age Concern advocacy contact information. Information about the right to advocacy and contact details for local services and the nationwide advocacy service is included in the information pack given and explained to residents and families on admission. Records of a case review where advocacy had been arranged by a family member to support the resident indicates that residents have open access to advocacy and relevant matters are brought to the attention of the manager. Consumer rights training including the right to advocacy / support has been provided for staff in the last two years. Relevant ARC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open visiting policy in place. Visitors were observed to be made welcome. Interviews with residents and family members and observation during the audit confirm that they may freely receive visitors and may entertain their visitors in the lounge in each area or one of small alternative sitting areas, also in the privacy of their own rooms. Links with community resources are supported and facilitated. There is evidence of interaction with Age Concern, Alzheimers Society, Stroke Foundation, District Health Board Maori Unit, District Health Board nurse specialist and gerontology nurse, Auckland University and Auckland University of Technology.Families are encouraged to take their resident out if physically able. Suitable residents are taken on trips into local community in the facility car. Arrangements for attendance at specialist appointments are facilitated by staff as required. Relevant ARC requirements are met. |

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

Consumers have access to visitors of their choice.

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

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

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

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Information about the complaints process is included in the resident admission pack. The process and forms are available in the entrance foyer. The resident's right to complain is discussed with the resident and family by the facility manager or the registered nurse during the admission process. Interviews with residents and relatives confirm awareness of their right to make complaints if they wish.  The complaints register and associated records indicate effective and timely handling of complaints in accord with Right 10 of the Code. Complaints and concerns expressed to staff are written in a book in each area but these are not transferred into the complaints register.Improvement is required to ensure that the concerns and complaints written in the books held in the wings are entered in the complaints register. There have been no major complaints since the last audit and none reported to the Health and Disability Commissioner. ARC requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Complaints and concerns expressed verbally to staff are written in a complaints book maintained in each area but these complaints are not transferred into the facility complaints register. A previous corrective action relating to ensuring that all complaints are entered in the complaints register has been only partly met and further action is required. |
| **Finding:** |
| Verbal complaints documented in complaints and concerns books in the rest home and the hospital are not entered in the complaints register. |
| **Corrective Action:** |
| Ensure that all concerns and complaints are entered in the complaints register. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seadrome mission and goals are displayed at the front entrance of the facility. They have been reviewed in Jaunary 2013 and are appropriate for an aged care facility providing residential care for people with dementia at rest home and hospital levels. A previous improvement required in relation to maintaining annual reviews has been addressed. Staff interviewed are aware of the mission and goals of the facility. The facility manager is a registered nurse and has been in the position for 22 years. She has previous experience in the care of aged people with psychiatric problems and evidence of ongoing relevant education. She is assisted by a clinical quality coordinator who is a registered nurse with current practising certificates and relevant ongoing training in aged care including dementia care. Relevant ARC requirements are met. |

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

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

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

##### **Criterion 1.2.1.3 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a registered psychiatric nurse facility manager with responsibility for operational management of the service who has been in this position since January 1990. The extensive prior experience of the facility manager includes aged care facility management and care of the elderly. A registered nurse clinical quality manager is responsible for the coordination, delivery and supervision of clinical services. The clinical quality manager coordinates the quality programme and deputises for the facility manager in her absence. Both managers have maintained relevant on-going education. Review of the two job descriptions confirms that appropriate authority, accountability and responsibility are assigned to each role. Minutes of meetings held indicate that the facility manager meets with senior staff daily and with residents and the quality improvement team monthly to plan services, coordinate delivery and review outcomes. Formal staff meetings are held two monthly but the facility is small and the faciliy manager is in daily communication with the staff. Relevant ARC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a documented quality and risk management system in place. A Plan-Do-Check-Act model (PDCA) is used and quality and risk management requirements are included in the staff orientation programme and reviewed at monthly quality meetings and staff meetings.  Documented service delivery policies, procedures and guidelines sighted are relevant for the service provided and available to staff at nurses' stations.  There is a process in place to identify and control documents. The masters are electronic and access is protected by password. A previous improvement required in relation to ensuring that the hard copy versions in the manuals are the same as identified in the indexes, that there is a defined process for introduction of new or changed documents to staff, and that a copy of obsolete documents is kept for future reference has been addressed.  All aspects of service delivery are linked to the quality system. Quality data is collected, analysed and used to improve service delivery. Reports relating to infection control, health and safety, adverse events, complaints, internal audits, restraint (not used but de-escalation and education is reviewed), resident and family feedback, staffing, issues and risks are collected and collated by the quality coordinator and reviewed at monthly quality management meetings and staff meetings. Minutes sampled and records of adverse events and complaints indicate that the PDCA cycle is implemented and actions taken to correct or prevent recurrence of problems are reviewed at the quality improvement meetings.  There is a documented risk management process and plan that includes health and safety, hazard management, emergencies, staffing and staff competence, contractual compliance, resident safety and clinical care. There is a documented health and safety system in place and staff receive relevant training. Improvement is required to ensure that the six monthly hazard control checks are consistently maintained. The manager and clinical quality coordinator review and report risk processes and outcomes monthly to the owner. Relevant ARC requirements are met. |

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

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

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

##### **Criterion 1.2.3.3 (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.

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

##### **Criterion 1.2.3.4 (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.

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

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

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

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

##### **Criterion 1.2.3.6 (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.

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

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

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

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

##### **Criterion 1.2.3.8 (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.

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

##### **Criterion 1.2.3.9 (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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a documented risk management process includes a hazard management system and register of potential and actual hazards that identifies the controls in place and any residual risks .There is no evidence that the hazard controls are reviewed every six months and up dated where necessary. |
| **Finding:** |
| Six monthly health and safety checks have not been carried out against the hazard register in the last 12 months. |
| **Corrective Action:** |
| Ensure that the six monthly hazard control checks are consistently maintained. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Interview indicates that the facility manager is aware of all situations where it is required to report to the Ministry of Health, Government bodies such as ACC, the DHB, public health officer, police and other offices and bodies. There have been no notifications required since the last audit. Processes for recording and responding to adverse events are clearly documented. Staff interviewed are aware of their reporting responsibilities. Individual records are maintained for each event. Sampled records include details of the event, investigation, causes and remedial/ preventive actions taken with sign off by the manager. Quality Improvement Team meeting minutes sighted indicate that all adverse events are reviewed monthly by the team and actions taken to address any unwanted trends and improve outcomes where possible.Improvement is required to ensure that medication errors and ommissions are documented in the adverse events records system. All other relevant ARC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of 10 adverse event records and of monthly summaries of adverse events indicates that although medication errors and omissions are recorded and managed they are not documented as an adverse event. |
| **Finding:** |
| Not all adverse events are documented in the adverse events system, for example medication omissions and errors. |
| **Corrective Action:** |
| Ensure that medication errors and ommissions are documented in the adverse events records sytem. |
| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a suitable employment process in place. An organisation chart with reporting lines is documented. The skills and knowledge required for each position within the service are documented in job descriptions which outline accountability, responsibilities and authority. Employment processes are documented and comply with good human resources practice. Six of six staff records reviewed include evidence of interviews, reference checks, employment contracts and signed job descriptions. Staff interviews and review of the CVs of current incumbents indicates that appointments are appropriately made in accord with the skills and experience required in the job descriptions Professional qualifications and references are checked during employment processes. There is a process for annual verification of continuing certification for RNs, therapists and the doctor.  Staff receive an orientation to the facility and to the requirements of their position. The programme includes elements specific to the care of residents with dementia. Improvement is required to ensure that the programme includes response to relevant clinical emergencies, and implementation of activities and therapies for residents with dementia, that orientation records are maintained in personnel files for all staff, including bureau staff.   Staff training records sighted for 2013 and the programme for 2013 indicates that a planned programme of relevant training is implemented. There is evidence in staff training records that all care staff have done or are undertaking relevant education in the care of residents with dementia. Improvements are required to ensure that all staff complete training in relation to abuse and neglect, manual handling and verification of competency in using the hoists. All other relevant ARC requirements are met. |

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

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

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

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

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

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

##### **Criterion 1.2.7.4 (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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The orientation programme does not include response to clinical emergencies, nor implementation of activities and therapies for residents with dementia.  Review of personnel records of the five staff employed in the last twelve months indicates that three do not have records of completed orientation programmes in their file.  Bureau staff are occasionally employed. Staff interview indicates they receive an orientation to the facility and the residents they will be caring for prior to commencing the shift but the programme is not documented and individual records are not maintained. |
| **Finding:** |
| 1. The orientation programme does not include clinical emergency protocols nor implementation of activities and therapies for residents with dementia as required by the ARC. 2. Orientation records are not consistently maintained for all staff, for example, for three of five staff employed in the last 12 months, and for bureau staff. |
| **Corrective Action:** |
| 1. Revise the orientation programme to include clinical emergency protocols and implementation of activities and therapies for residents with dementia. Update all current staff. 2. Maintain orientation records in staff files. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of staff training records indicates that not all staff have completed required on-going training. For example - 1. Only 10 of the 29 staff have undergone training in relation to abuse and neglect in the last two years.  2. Only seven of 29 staff have completed manual handling training in the last two years. 3. Individual records of staff competency in using the three hoists have not been maintained. |
| **Finding:** |
| Not all staff have completed required training or competency verifications in relation to abuse and neglect education, manual handling and use of hoists. |
| **Corrective Action:** |
| Ensure that all staff complete education and training in relation to abuse and neglect, manual handling, and competency using hoists |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented process for the allocation of staff that complies with contractual requirements relating to numbers and skill mix and is appropriate for the layout of the facility. At least one registered nurse and three caregivers are on duty at all times providing two staff in each unit. There is evidence in rosters reviewed and from staff interviews that numbers and skill mix are sufficient to maintain safety and deliver the care required in the hospital and the dementia unit - seven days a week, 24 hours a day. The facility manager ( a registered psychiatric nurse) or the clinical quality coordinator (RN) are an call and staff report response is prompt. Review of adverse event records and staff meeting minutes indicates there have been no issues relating to staffing since the last audit.Relevant ARC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Resident demographic information is entered into the resident register on admission. The admission assessment includes verification and documentation of individual resident information in the resident paper file by the RN. There are documented consent and recording processes in place for access to resident files by persons other than the health professionals providing their care. Daily resident lists are maintained. Access to electronic records is guarded by individual password. Electronic data is backed up nightly and held securely off site.  Resident files are stored securely in the nurses’ station in both the dementia unit and hospital area. Review of resident records indicates that they include reports from all health professionals. Daily progress notes are maintained and records are integrated in the one file. Improvement is required to ensure that progress notes are sufficiently detailed to describe the current care and/or health needs of hospital residents. Resident records are identified by name and date of birth and are securely held in individual folders. Entries are legible, dated, signed and designated. A specimen signature list is maintained. The registered nurse interviewed states that in the event of transfer to hospital the relevant data accompanies the resident. Archived records are observed to be stored securely in a small room in the dementia unit and maintained for 10 years at which point they go into the secure document destruction bin. Entries are legible, dated, signed and designated.  Relevant ARC requirements are met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Progress notes are documented each shift, however not all relevant data has been documented. For example there is no record in the progress notes of a transfer from hospital and readmission to the hospital wing. Additionally an unwitnessed fall (the resident was found lying in the garden) is documented on an adverse event form, but there is no reference to this in the progress notes. |
| **Finding:** |
| Not all progress notes have been sufficiently documented to describe the current care and/or health needs of hospital residents. Examples include following an incident or admission to the hospital following transfer. |
| **Corrective Action:** |
| Maintain progress notes for all events. |
| **Timeframe (days):** 30 *(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.

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seadrome Home and Hospital operates twenty four (24) hours per day seven days per week. Information about the service is readily available on the Ministry of Health and Eldernet web sites. The Manager states that referring agencies are kept fully informed of bed availability and the eldernet web site is kept current.   The Manager is responsible for ensuring the entry process is delivered in a timely and equitable manner. Guidelines on entry criteria, assessment and screening processes are clearly documented. A record of all enquiries is maintained and an admission checklist is utilised to ensure all entry processes are occurring as required. Potential placements are discussed with staff if appropriate.   Residents are assessed as requiring rest home or hospital level care prior to entry. All residents have dementia. The required referrals/assessments are evident in the resident records sampled. Evidence of the completed admission documents is also sighted. For example consents, agreements and initial (short term) care plans.   The ARRC requirements are met. Full details regarding the resident's right to receive additional services is included in the resident agreement and the Work and Income brochure on how to apply for a subsidy is available if required. . |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an adequately documented process for the management of any declines to entry and waiting lists. The Manager is interviewed and states that refusals would only occur due to lack of bed availability. In this event the referrer is informed and the person is offered a place on the waiting list. The service currently has one bed available and there are five potential residents on the waiting list. Records of enquiries are maintained and followed up regularly. |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Each stage of service provision is completed by a suitably qualified person. All assessments and care plans are developed and reviewed by a registered nurse with a current practicing certificate. Daily interventions and support with activities of daily living are implemented with the help of trained health care assistants and allied health providers. All health care assistants have completed the required dementia training.   Timeframes for service delivery are defined and met as evident in the seven out of seven residents' files sampled. The sample includes four residents’ records from the dementia unit (rest home) and three from the hospital wing. An initial nursing assessment is performed on admission by the registered nurse and a medical assessment conducted by the GP within forty eight hours. Following this the long term care plan is developed and implemented to meet the identified needs and goals of the resident.   The multi-disciplinary process ensures a comprehensive review of care is completed every six months. This process includes the involvement of the multi-disciplinary team, the resident (if able) and family. The required reviews are sighted in files sampled and have been conducted within the defined timeframe.  Continuity of care is maintained through staff handovers between each shift, progress notes and a weekly clinical team meeting.   The ARRC requirements are met. Residents are assessed by their GP on entry. Responsibilities for the provision of daily care are identified during the handover reports. The care plans are comprehensive and include the required domains such as eating/drinking, toileting, personal hygiene, dressing/undressing, mobility/movement, physical health, communication, psychological health, therapies/activities, spiritual/cultural, sexuality, environment/risk, sleep/rest and nominated representative.  Tracer methodology for hospital resident. XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology for dementia unit (rest home).  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

##### **Criterion 1.3.3.3 (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.

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

##### **Criterion 1.3.3.4 (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.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| The registered nurses complete a number of assessments on admission inclusive of pressure, falls, incontinence, nutrition and oral health. A social history assessment and medical assessment is also completed. Non-verbal pain indicators are completed and base line observations, including weight, are recorded on admission, and there after monthly (or more frequently if required). The Cornell Scale and Mini Mental State Examinations are completed and the Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD) is completed with residents in the dementia unit. There is also a post fall assessment tool in use. Assessments are reviewed every six months during the care plan review.  Seven resident files are sampled. The sample is stratified and includes three hospital residents and four dementia unit residents. The required (and appropriate) assessments are sighted in all files samples. The results of the assessment process are then transferred onto the care plan with nursing outcomes and goals documented. Assessments are reviewed by the nurse and updated, as required, to reflect the current status of the resident. Family members interviewed report involvement in the assessment process and there are adequate areas within the facility to ensure assessments are conducted in private.   The ARRC requirements are met. Long term care plans sighted have been completed within three weeks of entry. Assessments sighted are commensurate with the current needs of the resident. All resident files sampled have the required assessment to determine suitability of placement. |

##### **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.

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| An initial (short term) care plan is developed on admission and a long term care plan developed within three weeks. The nursing process is used and care plans include a nursing diagnosis, goal and related interventions. The care plan is comprehensive and includes interventions for the following domains: eating/drinking, toileting, personal hygiene, dressing/undressing, mobility/movement, physical health, communication, psychological health, therapies/activities, spiritual/cultural, sexuality, environment/risk, sleep/rest and nominated representative.   Goals and timeframes are documented for each domain. Plans with goals are also documented for activities. Seadrome has recently commenced completing care plans using InterRAI and now has one care plan fully documented using the InterRAI process.   Interventions are documented within each domain of the care plan. Interventions sighted are commensurate with the nursing diagnosis and desired goals, however not all care plans make reference to additional interventions such has fluid balance charts for example.   A short term care plan is developed on entry and wound care plans are developed as required.  Resident files sampled evidence service integration. Sections exist for care, progress, correspondence, medical notes, adverse events, consents, family contacts, laboratory results, needs assessment correspondence, referral agencies, District Health Board letters and medical specialists records. Staff interviewed confirm they have access to residents' records/plans and are sighted completing their progress notes on the day of the audit.   The ARRC requirements are met. Initial assessments are completed on admission and family interviewed confirm input in the development of care plans. All care plans sampled address the required interventions for working with residents with behaviours of concern. Strategies are individualised and sufficient to manage to best manage behaviour over a 24 hour period. Where additional interventions are required a behaviour analysis is completed. This includes a review of antecedents, behaviour and consequences. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A number of clip boards are sighted which hold additional monitoring requirements for staff to complete. This includes fluid balance charts, turning charts, seizure chart and behaviour analysis charts. A cross reference to the additional monitoring requirements is not always documented in the care plan. |
| **Finding:** |
| Not all care plans make reference to the additional monitoring requirements |
| **Corrective Action:** |
| Cross reference the use of additional monitoring charts in the care plan. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Service delivery plans demonstrate service integration.

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Interventions are documented for each nursing objective/goal. Interventions sighted are well documented and consistent with best practice.  The GP interviewed is satisfied that clinical interventions are implemented in a timely and competent manner. Interventions from allied health providers are also given due consideration. For example input for mental health services or specialists. All care plans include interventions of how to manage behaviours of concerns.  Additional interventions are implemented as required. For example turning charts and fluid balance charts. There is a short term care plan for the management of wounds and a short term care plan which is completed on entry, however not all short terms needs have been sufficiently documented and an improvement is required.  The ARRC requirements are met. Care and support is flexible and restrictive practices are minimised. Seadrome provides a calm environment which maintains a sense of trust and security. This is confirmed in interviews with residents, no use of restraint and/or enablers and minimal adverse events regarding behaviours of concern. The provision of medical services is available 24 hours per day, seven day per week. If the GP is not available an after hour’s service is used. This is evident is records sighted. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a system in the dementia unit (rest home) for documenting short term needs, for example in the presence of an infection. This includes completion of the required infection data report and documenting short term needs in the progress notes. This process is sampled. However, this is not evident in the hospital wing and short term care needs are not sufficiently documented. |
| **Finding:** |
| Not all short term interventions have been recorded and/or monitored in the hospital. For example treatment during a urinary tract infection or maintaining fluid intake/output records. |
| **Corrective Action:** |
| Record and monitor all short term interventions. |
| **Timeframe (days):** 180 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activity programme is developed and coordinated by a registered diversional therapist (DT). The DT has been at Seadrome for 16 years and is employed for 32 hours per week. The Seadrome activities plan is sighted and provides a sufficient range of planned activities to develop and maintain strengths and interests. Activities are varied between both the dementia unit and the hospital wing.  Each resident has a social/activities assessment completed on entry. From this an individual activities care plan and goals are developed. Records of individual attendance at activities is documented. The multi-disciplinary review process includes a review of participation.   Residents are observed partaking in activities during the audit. This includes Tai Chi and music (ukulele). The DT is also observed providing one-to-one reading with a resident.   Seadrome Home and Hospital has demonstrated a strong commitment to ensuring residents are reaching their full potential and engaging with their environment. This is evident in the research project ‘Coming to Our Senses’ and the project group commencing in 2014 in collaboration with the local secondary school. Staff are also committed to implementing activities and use their individual skills to encourage residents’ participation. This ensures a level of participation is achieved throughout the day and into the evening if required. A continuous improvement rating has been allocated in 1.1.8 regarding the recent innovations.  The ARRC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plans are reviewed every three months, with a multi-disciplinary (MDT) review every six months. The MDT review process includes a comprehensive review of care. The required MDT’s are sighted in resident records sampled. These include input from the nurses, manager, DT, GP and family (where available). One family member interviewed shows the auditor a copy of the notes that had been taken from the MDT in order for them to be able to provide other family members with an update on progress.   A review of assessments is also completed at the MDT review. If required, care plans are updated accordingly and this is evident in the sample.  Daily checklists are completed by staff who indicate achievement in activities of daily living. Three monthly GP reviews are also evident in resident files sampled.   The relevant ARC requirements are met. |

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

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

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

##### **Criterion 1.3.8.3 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The GP interviewed states that support for access or referral to another health and disability provider is facilitated in a timely and proficient manner. The GP confirms involvement in the referral process. The two registered nurses interviewed state that a formal referral process exists which includes the identification of risk and involvement of family (if available). Evidence of recent referrals are sighted in the resident files sampled. For example a referral to mental health services for one resident and a referral to gynaecology services for another.  The ARRC requirements are met. Residents interviewed state they have access to the community and allied health services of their choice |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Planned transfers are preferable and conducted in collaboration with the resident and family (if available) to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner and that the needs of residents are paramount. There is also a defined and well implemented process, for the management of emergency transfers to inpatient services and this is evident in the resident files sampled.   Nurses interviewed state that in the event of a discharge/transfer the resident's records are copied and necessary data transferred with the resident. The GP interviewed confirms involvement in the discharge/transfer process.  The nurse in the hospital wing states that in the event of an internal transfer, the care plan and assessments are reviewed to ensure currency.  The ARRC requirement is met. The resident admission agreement includes the reasons for termination. |

##### **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.

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

#### 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines.   A blister pack medication system is implemented. All medicines are prescribed by the GP using the pharmacy generated medication chart. The service has one GP. All medication charts include photo identification and allergies. Three monthly GP reviews are evident in all records sampled.  Medications are safely stored in a locked medication trolley in both the dementia unit and hospital wing. Non packaged medications are safely stored and individually labelled. There is limited stocked medication in the hospital. All stocked medication requires an individual prescription by the GP. There is only one standing order in place. This is for the use of oxygen. The standing order meets the requirements of the 2012 standing orders guidelines.  Controlled drugs are stored in a secure manner. Controlled drugs checks are maintained. There is currently one person prescribed ‘as required’ pain medication.  Medications are administered by the registered nurses. Competencies for medication management are conducted as required. Records are sighted to verify the process. A lunch time medication round is observed in the hospital and confirms administration is safely maintained.   Medication charts are sampled in both areas. Unexplained gaps are sighted in four out of seven medication administration records in the hospital wing and an improvement is required. The process for reporting medication errors is well documented in policy; however the incident reporting process had not been used to report the unexplained gaps, or errors, in the medication recording system. An area of improvement has been documented in criterion # 1.2.4.3.  There are no residents who self-medicate.  The remaining ARRC requirements are met. Policies comply with the Medicines Act 1981 and residents' medication is reviewed on entry to the facility. This includes medication reconciliation. |

##### **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.

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

##### **Criterion 1.3.12.3 (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.

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

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

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

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

##### **Criterion 1.3.12.6 (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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Four errors/omissions are sighted in medication management information. This includes a progress note (16 October 2013) which stated the resident was administered XXXXXX prn, however there is no record of this in the medication chart. The resident was in fact administered XXXXXXXX. Three additional omissions are sighted in the 14 administration records sampled. One progress note stated the medication was given as charted (2 October 2013) with no corresponding signature in the administration record. The other two have no responding documentation. On investigation, it transpires that one hospital resident goes to the dementia wing during the day and has occasionally missed the midday medication. The system for ensuring the resident consistently receives the mid-day medication (when visiting the dementia wing) is reviewed and remedied on the day of the audit. Refer criterion # 1.2.4.3 regarding reporting of medication errors. It is also noted during the audit that one resident is prescribed a medication that they have an (alleged) intolerance to. This is discussed with the GP during interview. |
| **Finding:** |
| Medication administration has not been consistently maintained. For example there are unexplained gaps in four out of seven administration records sampled in the hospital and one resident had not been consistently receiving their mid-day medication. |
| **Corrective Action:** |
| Provide evidence that administration is consistently maintained for residents in the hospital wing. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents are provided with a well-balanced diet which meets their cultural and nutritional needs. The menu has been reviewed by a registered dietician in the last year and confirms it is appropriate for the nutritional needs of the older person. Deviations from the menu, occurring as a result of the availability of fresh produce, or in response to individual likes and dislikes, are recorded.   Nutritional assessments are completed on entry. Special dietary needs are identified and the cook confirms knowledge of the dietary needs, allergies, likes and dislikes of each resident. For example there is currently one vegetarian. There is a sufficient system in the kitchen to quickly identify special needs.  Residents are weighed monthly and confirm nutritional needs are being sufficiently addressed. Where required, additional nutritional support is documented and appropriate interventions implemented. This includes referrals to a dietician as required. The GP reviews weight charts during medical review.   A resident survey conducted in March 2013 confirms general satisfaction with the food provided. The meal service is observed on both days of the audit. Meals appear well presented and sufficient in quantity. There are sufficient staff available to provide support to residents during meals times and the cook confirms that resident’s can asked for additional food, snacks at any time. This is observed during the audit. Residents receive adequate fluids. Drinks are served with every morning and afternoon tea and at each meal time. Hydration levels for residents who are consistently moving are monitored and fluid balance charts documented.  The cook is interviewed and has the required food safety qualifications. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry is sighted and is clean, well-stocked and tidy. Labels and dates are on all containers. Temperature monitoring of the chiller and freezers are required twice daily, however there have been some days where no record has been recorded and an improvement is required. Meals are taken to the hospital wing in a bain maree. Food temperatures are taken prior to leaving the kitchen.  The DT has a group of residents who belong to the ‘breakfast group’. These residents are able to prepare their own breakfasts and are supported to do so.  The ARRC requirements are met. |

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

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

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

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

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

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

##### **Criterion 1.3.13.5 (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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are several gaps in the temperature monitoring records of the chiller/freezer. This is occurring on the weekends. |
| **Finding:** |
| Temperature monitoring of the chiller/freezer have not been maintained. |
| **Corrective Action:** |
| Maintain temperature monitoring requirements in the kitchen. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Staff comply with documented processes for handling hazardous substances. Improvement is required to ensure that a hazardous substances register is documented and maintained, the oxygen bottles in the treatment room are restrained from falling over, and the credentials of the gasfitter are available on site. Observation during the audit confirms that processes for the collection, storage and disposal of biomedical waste, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements. Rubbish bins are stored in an area accessible to residents. Improvement is required to ensure that rubbish bins are not overfilled, are locked to prevent interference from wandering residents and animals, and the credentials of the waste contractor are available on file.   Cleaning staff have received training in the handling of chemicals and hazardous waste. Chemicals are delivered to users via an Oasis dispensing system. Secure storage and dispensing systems are provided for chemicals. Improvement is required to ensure that there is a hazardous substances register identifying the location of cleaning chemicals and other hazardous substances. Material Safety data Sheets are available in the laundry and cleaner's room. Personal protective equipment is provided and observed to be used by staff. Minutes of monthly quality and safety meetings confirm that any issues related to chemicals or waste are reviewed and promptly resolved. Relevant ARC requirements are partly met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are various cleaning chemicals and laundry chemicals stored on site in the laundry, cleaner’s room and the outside shed. There is no hazardous substance register to identoify their location. Two oxygen bottles were noted to be standing against the wall in the treatment room in front of a cupboard door where they could be knocked over. Bottled gas is used for the cooking appliances. The credentials of the gas fitter who maintains the gas supply system are not available on file.  Bins for storing large bags of medical waste are placed beside a walkway used by residents. The bins are overflowing and are not locked to prevent interference from people or animals. The credentials of the waste contractor are not available on site. |
| **Finding:** |
| 1. Processes for managing hazardous substances are not applied in the following situations - • A hazardous substance register is not maintained. • Two oxygen bottles stored in the treatment room are not restrained. • The credentials of the gas fitter who maintains the gas delivery system are not available.  2. Processes for managing waste are not consistently applied.  • Rubbish bins stored in an area that is accessible to wanderers are over full and not secured.  • The credentials of the waste contractor are not available. |
| **Corrective Action:** |
| 1. Consistently implement the following processes for managing hazardous substances and waste –  • Develop and maintain a hazardous substance register. • The oxygen bottles have been chained to the wall, No further action required. • Acquire and maintain a copy of the gas fitters credentials on file.  • Acquire and maintain a copy of the waste removal contractor’s credentials on file. • It is noted that the bins have been emptied and arrangement made to increase clearance to three times a week. The bins are now secured with a padlock. No further action required. |
| **Timeframe (days):** 90 *(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.

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

#### 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a planned maintenance programme and the building is well maintained. Furnishings, fittings and floorings are well maintained and suitable for the care and support of elderly, dependent residents. Improvement is required to ensure minor superficial maintenance is dealt with promptly. Some bedrooms have doors to external decks with balustrades. The doors can be freely opened from inside but cannot be opened from outside providing security from intruders. Applicable building regulations and requirements are met. There is a current building warrant of fitness, expiry date 02 October 2014. Large, well-furnished lounge and dining areas are provided in the rest home and the hospital with additional small sitting areas. Handrails are provided in all corridors. A ramp to a lower level has non slip floor covering and a handrail.There is sufficient space for the use and storage of mobility aids. Telephones and mail services are readily available. Sufficient equipment and supplies are provided to meet the care needs of the residents. The hoists and weighing scales are functionally maintained and calibrated annually. Improvement is required to document an asset list identifying the items of equipment and appliances used in service delivery and which require regular functional, electrical or calibration checks to ensure that none are overlooked. A further improvement is required to ensure that there is a process in place to ensure that all items of electrical equipment are maintained in a safe condition and to ensure that digital thermometers and sphygmomanometers are calibrated at least annually. Improvement is required to ensure that the credentials of tradespersons providing these services are available on site.  Residents are transported to external appointments and events in a car with current registration and warrant of fitness. Improvement is required to ensure that evidence of the currency of drivers’ licenses is maintained and that there are guidelines for passenger numbers, escorts and use of seat belts. Enclosed gardens and safe, sheltered external areas with suitable seating are available for the use of residents in the rest home and hospital. A separate, sheltered area is provided for use by smokers. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit on to the road The deck outside the rest home unit has safety balustrades but there is an unguarded set of stairs leading down into the garden. Improvement is required to ensure that a suitable safety gate is installed to prevent falls down the stairs. There are paved pathways for residents to walk in the grounds. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit onto the road. Relevant ARC requirements are partly met. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Interview with the manager and visual inspection indicates that equipment used in service delivery is maintained in safe working condition but there are no records to verify this. There is no evidence of electrical safety checks or calibration of measuring equipment. The credentials of trades people providng these services are not available on site. Inspection identified minor superficial repairs that need to be done, for example a broken light switch in a shower room, a hole in a bedroom wall exposing plaster and chipped and worn paintwork in a shower room making it difficult to clean. |
| **Finding:** |
| The system for ensuring that equipment used in service delivery is maintained in a safe condition is not consistently implemented -  • There is no list identifying equipment requiring functional, electrical or calibration checks. • There is no process in place to ensure that all items of electrical equipment are maintained in a safe condition. • There is no process in place to calibrate the digital thermometers or the sphygmomanometers. • The credentials of the service person maintaining the hoists are not available  Repairs are not consistently maintained in all areas. For example – • Broken light switch in a bathroom • Hole in a bedroom wall. • Chipped and worn paintwork in a shower room. |
| **Corrective Action:** |
| Consistently implement all processes in relation to management of equipment - • List and identify all equipment requiring functional, electrical or calibration checks. • Develop and implement a process to ensure that all items of electrical equipment are maintained in a safe condition. • Develop and implement a process to calibrate the digital thermometers or the sphygmomanometers. • Obtain and maintain a copy of the credentials of the serviceperson maintaining the hoists.  Undertake repairs in relation to – • Broken light switch in bathroom 26 • Hole in the wall of bedroom27. • Chipped and worn paintwork in shower room 21. |
| **Timeframe (days):** 90 *(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.

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The deck outside the rest home unit has safety balustrades but there is an unguarded set of stairs leading down into the garden down which unattended residents could fall. Residents are transported to outside appointments in a facility car. The transport guidelines include requirements realting to the safety of the vehicle and the licensing of drivers but do not address how many residents may be transported on a trip, how many staff must accompany them, and management of seat belts on residents with dementia. |
| **Finding:** |
| There is no safety gate to prevent residents from falling down a short flight of steps leading down from the deck outside the dementia rest home unit to the garden.  Transport processes are not sufficiently defined in relation to guidelines for resident numbers, escorts and use of seat belts when residents are transported in the car. |
| **Corrective Action:** |
| Install a safety gate to prevent unattended residents falling down the stairs from the deck to the garden.  Clearly define guidelines in the transport policy for resident numbers, escorts and use of seat belts |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are sufficient individual toilets and bathrooms provided in each wing for the number of residents. Some bedrooms have ensuites. Bathrooms are well lit, fitted with hand rails, non-slip flooring, and call bells. Finishing materials are waterproof and in good condition. Reversable door catches and privacy curtains are installed in each bathroom. |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are sufficient bedrooms to accommodate 25 residents in the rest home and 20 residents in the hospital. Rooms used for hospital residents are of sufficient size to accommodate residents requiring hospital level care, allowing for mobility aids, equipment and staff caring for the resident. Electric beds are provided for hospital residents. There is adequate room in all bedrooms for personal possessions. Each bed space is provided with a wall light and a nurse call bell. Residents and relatives interviewed confirmed that their bedrooms were adequate for their needs and their personal space is respected. Relevant ARC requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are separate well-furnished lounges and dining areas for the hospital and the rest home. Activities are provided in the lounge areas and in further separate recreation room. Alternative additional small sitting areas are available in each area. The communal areas are sufficient to acoommodate all the residents. There is a variety of seating to suit all needs. There is room to accommodate wheelchairs and walkers. Residents and relatives interviewed confirm that the lounges and dining areas meet their needs. Relevant ARC requirements are met. |

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Laundry services are provided on site in an area that is fit for purpose. The room has good separation of clean and dirty areas and laundry processes meet good practice guidelines. Maintenance, functional testing and temperature records sighted indicate the laundry processes meet infection control standards. Interviews with staff, residents and relatives indicate satisfaction with facility cleanliness and the state of linen and personal clothing.  Cleaning services are provided by employed staff. Interview with one of the cleaners, review of internal audit records and visual inspection indicate that cleaning meets infection control requirements and is of a high standard. A well-equipped cleaning trolley with secure storage for chemical containers, and a secure cleaning room is provided. The cleaner is aware of the need to store the trolley securely when it is unattended and this was observed throughout the two days of the audit. The cleaners are trained by Ecolab in the use of equipment and chemicals. Documented material safety data sheets are available in work areas. The manager monitors cleanliness and laundry standards daily. Cleaning audits are included in the internal audit schedule. Records reviewed months indicate any deficits are remedied promptly. A pest control programme is in place. Relevant ARC requirements are met. |

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

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

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

##### **Criterion 1.4.6.3 (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.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a current approved evacuation scheme. There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months and all staff have attended at least once. There are no documented guidelines for responding to relevant clinical emergencies and improvement is required to ensure that protocols are developed and staff receive training. There is a pandemic response plan that is currently under review in relation to the special needs of residents with dementia. Improvement is required to develop a business continuity plan to maintain the safety of residents during and after a civil emergency.  Emergency equipment provided includes a first aid kit in each wing, an ambu bag and airways, bottled oxygen and a portable suction. Improvement is required to ensure that there are documented protocols for managing relevant clinical emergencies, that all staff have current first aid certificates and relevant training in response to clinical emergencies.  All bed spaces, bathrooms and toilets have a nurse call bell. These were seen to be within easy reach of the resident. The location of the call shows on electronic light boards in the rest home nurses station and the lounge and corridor in the hospital. Functional checks are done monthly. Improvement is required to ensure there are risk management processes in place to ensure that residents in the rest home where pull cords have been removed from the call bells receive prompt assistance when required.  A suitable security policy and lock down process is in place and staff interviews indicate it is implemented .  There are civil emergency supplies on site. Emergency supplies in case of loss of services include sufficient stored water, food, continence supplies and toilet paper for at least three days. Emergency power batteries are checked monthly and will last for two hours. There are lantern torches and a supply of extra batteries, a solar powered radio, and a gas barbecue for cooking. Heating is partly electric and partly gas. There is a supply of extra blankets for warmth. ARC requirements are partly met. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is no business continuity plan to maintain the safety of residents during and after a major internal or civil emergency. There are no documented protocols for managing relevant clinical emergencies. Review of staff training records indicates that two of the six RNs do not have current first aid certificates and training in management of relevant clinical emergencies is not provided.   There are no guidelines for trips in the car in relation to the number of residents per trip, the ration of staff escorts to reisdents, and the use of seat belts with residents with dementia. |
| **Finding:** |
| Systems to manage emergencies do not include – 1. Protocols for and staff training for management of relevant clinical emergencies. 2. CPR and first aid training for all care givers.  4. Business continuity plan for maintaining safety of residents in a major utility outage or a civil emergency.  Transport processes fro trips out in the car are not sufficiently defined in relation to guidelines for resident numbers, escorts and use of seat belts |
| **Corrective Action:** |
| 1.Develop protocols and train staff in relation to relevant clinical emergencies 2. Ensure that all staff have CPR/first aid training. 3. Develop a continuity plan for maintaining safety of residents in a major utility outage or a civil emergency.  Define guidelines resident numbers, escorts and use of seat belts when transporting residents in the car. |
| **Timeframe (days):** 60 *(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.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The call bell system does not have an emergency call function and there is no alternative means of indicating an emergency call has been made.  The pull cords have been removed from the call bells in residents’ rooms in the rest home area as a safety measure to prevent residents from entangling themselves. The push button stilll works and staff monitor the whereabouts of residents all the time. There is still a risk that residents who need assistance will not be able to summon a nurse. |
| **Finding:** |
| There is no emergency call function in the call bell system and no other emergency call has been identified or implemented.. There is no risk management plan in place to identify and coordinate the measures that have been put in place to ensure that residents in the rest home receive prompt assistance as required. |
| **Corrective Action:** |
| Identify and implement an emergency call system.  Identify and document the strategies put in place to ensure that residents in rest home bedrooms receive prompt assistance as required. |
| **Timeframe (days):** 7 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The facility has plenty of natural light . All bedrooms have at least one good sized window that opens and some have doors to the garden. There is plenty of natural ventilation. Improvement is required to ensure that ventilation fans in showers with no windows are maintained in working condition. The hospital wing has underfloor heating with thermostat controls in each bedroom. There are wall mounted electric panel heaters in communal rooms, corridors and bedrooms in the rest home. Improvement is required to provide some means of heating in bathrooms. Observation during the audit and interview with residents and family members indicate that the internal environment is maintained at a comfortable temperature for the residents. The facility is smoke free indoors. A small sheltered area with fire proof receptacles for the use of smokers is provided in a courtyard. Relevant ARC requirements are met |

##### **Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

Areas used by consumers and service providers are ventilated and heated appropriately.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The ventilation fan in a shower room with no window for natural ventilation does not work. The room had just been used and was very stuffy and stale. The shower rooms throughout the facility have no means of heating. |
| **Finding:** |
| The ventilation fan in a shower with no window does not work. There is no means of heating the shower rooms. |
| **Corrective Action:** |
| Repair the fan in shower 25. Provide means of heating in the shower rooms. |
| **Timeframe (days):** 90 *(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.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Seadrome Home and Hospital uses no restraints and no enablers. There is no evidence of restraint/enabler use during the audit.   There are adequately documented guidelines on the use of restraints and enablers. Definitions are congruent with the requirements of the Health and Disability Sector Standards. There are also guidelines on the management of behaviours of concern and staff receive adequate training. The self learning package on restraint and enablers is mandatory and clearly describes the voluntary use of enablers.   The Manager is interviewed and states the need for restraint and/or enablers is minimised by the use of appropriate equipment. For example low beds. Staff are also competent in de-escalation techniques. Staff are observed managing all behaviours in a competent and safe manner.  The ARRC requirement is met. Restrictive practices are effectively minimised and not evident during the audit. |

##### **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.

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control policy is clearly documented and is suitable for the facility and the level of care provided.  There is a designated infection control nurse and their Infection control responsibilities are clearly documented in the terms of reference. Adequate information, resources and on-going training are provided. External expert advice is sought to ensure that infection prevention and control processes are up to date. Infection control reporting is included in health and safety, quality and risk management, and emergency systems. The infection prevention and control programme is reviewed annually and was last reviewed in March 2013 with input from an infection control specialist.   Interview with the infection control nurse and review of seven resident records indicate that an infection record is maintained for each resident documenting type, treatment and duration.  There is documented evidence that staff, management and the quality committee receive monthly reports on infection related issues. This is evident in staff meeting minutes and displayed infection reports.  The ARRC requirement is met. |

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

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

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

##### **Criterion 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.

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

##### **Criterion 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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An infection control plan is developed annually. The 2013 plan is sighted and includes three goals. To protect residents, protect staff and visitors and reduce infection rates.  The infection control programme defines appropriate responsibilities for the infection control coordinator and team that are appropriate for the level of services provided. The infection control nurse confirms that designated time is provided for infection control management activities, as are and sufficient resources. For example all staff carry their own hand gel in their pocket.  The nurse reports to management and has access to current information relevant to the size and complexity of the facility including infection control manuals, internet and expert advice from the DHB nurse specialist and laboratory specialist.   The ARRC requirement is met. |

##### **Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)**

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented policies and procedures are in place for the prevention and control of infection. The protocols are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures are written in a user friendly format, contain appropriate level of information and are developed and reviewed annually in consultation with an infection control specialists.  Policies are readily accessible to staff in service areas. Policies and procedures identify links to other documentation in the organisation. For example health and safety, quality and risk. Clinical staff interviewed confirm infection control policies and procedures are freely available for them.  Policies and procedures include hand washing, cleaning and sterilisation, standard precautions, isolation, outbreak management, management of staff with infections, health and safety, and a list of notifiable diseases.  The ARRC requirement is met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Education on infection prevention and control is mandatory for all staff. An introduction to the infection control plan is included in orientation and inservice training in provided in line with the ARRC requirement. Staff training in provided by the infection control nurse, or management. Refer criterion # 1.2.7.5.  Resident education occurs in an appropriate manner. All residents have access to adequate hand washing facilities/equipment and hand washing signage is displayed. The last outbreak was prior to the last certification audit; however the nurse reports that the required education and visitor signage was available and communicated as required. The outbreak was contained.  The ARRC requirement is met. |

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

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

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

##### **Criterion 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.

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

#### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection surveillance programme is appropriate for the facility and the level of care provided. Surveillance is conducted on infections of the urinary tract, gastrointestinal tract, and eyes, upper and lower respiratory tract and fungal infections. An infection data sheet is used to record all infections. This includes signs and symptoms. Infection reports are collated every three months and an analysis documented. Use of antibiotics is monitored and specimens are required for diagnostic purposes. Collated reports are then reported to the quality committee.   Seadrome infection data reports reflect that infections are well managed. The July-September 2013 infection control data confirms seven infections in the hospital over that time (with 45 antibiotic days) and six infections in the dementia unit (with 40 antibiotic days).  The six monthly MDT review also includes review of any infections and the outcome of treatment.   Doctors are informed if their resident has an infection. |

##### **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.

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

##### **Criterion 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.

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