# Kingswood Healthcare Morrinsville Limited

## Current Status: 10 December 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

Kingswood Rest Home, located in Morrinsville, provides rest home and specialist dementia care service. The service also has separate independent living apartments, which are not included as part of this certification audit. One of the strengths of the service is the implementation of the ‘Spark of Life’ approach to care in the specialist dementia service. The Spark of Life is a practical implementation of person centred care to support people living with dementia.

There is one area requiring improvement relating to the documentation of advance directives identified at this audit.

## Audit Summary as at 10 December 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 10 December 2013

|  |  |  |
| --- | --- | --- |
| 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 10 December 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 10 December 2013

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

### Safe and Appropriate Environment as at 10 December 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. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 10 December 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 10 December 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 10 December 2013

### Consumer Rights

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.  
  
Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.   
  
Evidence is seen of informed consent and open disclosure in files reviewed. The advocacy service visits every twelve months for staff education and attendance at residents' meetings.   
  
There is a complaints policy which details those residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints folder is maintained which details dates of complaints and actions undertaken.  
  
There is an area for improvement relating to advanced directive forms not meeting legislative requirements.

### Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the specialist dementia unit incorporate the Spark of Life approach for person centred care. The general manager has appropriate experience and qualifications to perform this role and is responsible for the overall service delivery, business administration, quality systems and human resources management. The general manager is supported by a full time registered nurse (RN) and has support and advice through an external nurse practitioner for the clinical aspects of service delivery.   
  
The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme for 2013 is in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management reflecting current accepted good practice.   
  
The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery in the rest home and in the dementia unit. Rosters and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. All staff are provided with ongoing education on the Spark of Life and the required national unit standards in dementia care. The education programme is available for 2013 and education records are well maintained.   
  
Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

### Continuum of Service Delivery

Kingswood Rest Home has pre-entry and entry services which are organised by the general manager and the registered nurse. These are supported by policies and entry information material. Included, is the referral process with assessments being performed by the Needs Assessment Co-ordination Service.  
  
The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the GP along with other health service providers.   
  
The activities programme is overseen by two activities co-ordinators who work a total of 50 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.  
  
Medicines are managed safely and meet all legislative requirements. Education and medicine competencies are completed by all staff responsible for the administration of medicines. The medication records reviewed include documentation of allergies and sensitivities. No residents self-administer medicines.  
  
The food service policies and procedures are appropriate for residents requiring rest home and dementia unit level care. All resident’s individual needs are identified, documented and choices are available and provided. Meals are well presented, homely and the menu plans have been audited. The residents have a seasonal menu and a contracted dietitian reviewed the menu in May 2013. Staff have completed appropriate food hygiene education and food hygiene and legislative requirements are met. Positive comments are received on meals as part of the resident satisfaction survey.

### Safe and Appropriate Environment

The service provides rest home and specialist dementia care in separate buildings. The specialist dementia unit was constructed in 2013, and has a current certificate for public use. The existing rest home building has a current building warrant of fitness. The evacuation plan is approved by the fire service.   
  
There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. The laundry service is provided by an externally contracted organisation. The service complies with requirements related to safe and hygienic storage of cleaning/laundry equipment and chemicals.   
  
The building has appropriate systems in place to ensure the residents' physical environment is fit for their purpose. All buildings, plant and equipment comply with legislation. The internal and external areas of the specialist dementia unit are safe and secure for residents with cognitive impairment. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.   
  
The rest home has an appropriate call system for residents to request assistance from staff. The specialist dementia unit has a ‘panic’ call bell system that is available for staff.

### Restraint Minimisation and Safe Practice

The service has a restraint free environment and does not have any recorded restraint or enabler use. The care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard.

### Infection Prevention and Control

There is a documented infection prevention and control programme which is approved and facilitated by the general manager. All required infection prevention and control policies and procedures are available for staff. These policies have been recently reviewed.  
  
Staff participate in relevant ongoing infection prevention and control education. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurse and caregivers in a timely manner. Overall infection rates and trends are discussed at the monthly staff meetings.

# 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:** | Kingswood Healthcare Morrinsville Limited |
| **Certificate name:** | Kingswood Rest Home Morrinsville |

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| --- | --- |
| **Designated Auditing Agency:** | DAA Group |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | 422A Thames Street, Morrinsville | | | |
| **Services audited:** | Rest Home and Specialist Dementia Care | | | |
| **Dates of audit:** | **Start date:** | 10 December 2013 | **End date:** | 11 December 2013 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 28 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **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** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 19 | Total audit hours | 51 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 10 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 15 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXX, Director of Wellington 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:

|  |  |  |
| --- | --- | --- |
| 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 | Not Applicable |
| 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, 7 January 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Kingswood Rest Home, located in Morrinsville, provides rest home and specialist dementia care service. The service also has separate independent living apartments, which are not included as part of this certification audit. One of the strengths of the service is the implementation of the ‘Spark of Life’ approach to care in the specialist dementia service. The Spark of Life is a practical implementation of person centred care to support people living with dementia. There is one area requiring improvement relating to the documentation of advance directives identified at this audit. |

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| **Outcome 1.1: Consumer Rights** |
| Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.  Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.   Evidence is seen of informed consent and open disclosure in files reviewed. The advocacy service visits every twelve months for staff education and attendance at residents' meetings.   There is a complaints policy which details those residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints folder is maintained which details dates of complaints and actions undertaken.  There is an area for improvement relating to advanced directive forms not meeting legislative requirements. |

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| **Outcome 1.2: Organisational Management** |
| Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the specialist dementia unit incorporate the Spark of Life approach for person centred care. The general manager has appropriate experience and qualifications to perform this role and is responsible for the overall service delivery, business administration, quality systems and human resources management. The general manager is supported by a full time registered nurse (RN) and has support and advice through an external nurse practitioner for the clinical aspects of service delivery.   The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme for 2013 is in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management reflecting current accepted good practice.   The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery in the rest home and in the dementia unit. Rosters and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. All staff are provided with ongoing education on the Spark of Life and the required national unit standards in dementia care. The education programme is available for 2013 and education records are well maintained.   Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Kingswood Rest Home has pre-entry and entry services which are organised by the general manager and the registered nurse. These are supported by policies and entry information material. Included, is the referral process with assessments being performed by the Needs Assessment Co-ordination Service.  The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the GP along with other health service providers.   The activities programme is overseen by two activities co-ordinators who work a total of 50 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.  Medicines are managed safely and meet all legislative requirements. Education and medicine competencies are completed by all staff responsible for the administration of medicines. The medication records reviewed include documentation of allergies and sensitivities. No residents self-administer medicines.  The food service policies and procedures are appropriate for residents requiring rest home and dementia unit level care. All resident’s individual needs are identified, documented and choices are available and provided. Meals are well presented, homely and the menu plans have been audited. The residents have a seasonal menu and a contracted dietitian reviewed the menu in May 2013. Staff have completed appropriate food hygiene education and food hygiene and legislative requirements are met. Positive comments are received on meals as part of the resident satisfaction survey. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service provides rest home and specialist dementia care in separate buildings. The specialist dementia unit was constructed in 2013, and has a current certificate for public use. The existing rest home building has a current building warrant of fitness. The evacuation plan is approved by the fire service.   There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. The laundry service is provided by an externally contracted organisation. The service complies with requirements related to safe and hygienic storage of cleaning/laundry equipment and chemicals.   The building has appropriate systems in place to ensure the residents' physical environment is fit for their purpose. All buildings, plant and equipment comply with legislation. The internal and external areas of the specialist dementia unit are safe and secure for residents with cognitive impairment. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.   The rest home has an appropriate call system for residents to request assistance from staff. The specialist dementia unit has a ‘panic’ call bell system that is available for staff. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a restraint free environment and does not have any recorded restraint or enabler use. The care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. |

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| **Outcome 3: Infection Prevention and Control** |
| There is a documented infection prevention and control programme which is approved and facilitated by the general manager. All required infection prevention and control policies and procedures are available for staff. These policies have been recently reviewed.  Staff participate in relevant ongoing infection prevention and control education. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurse and caregivers in a timely manner. Overall infection rates and trends are discussed at the monthly staff meetings. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.10: Informed Consent | Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.10.7 | Advance directives that are made available to service providers are acted on where valid. | PA Low | In four of the six files (three rest home and one dementia) reviewed the advanced directive forms do not comply with the standard. | Ensure residents advance directive forms comply with legislative requirements. Staff undertake education relating to advance directives. | 180 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Dementia and Rest Home: The ten staff interviewed two RNs, four caregivers, one cook, one house keeper, two activity coordinators) are able to demonstrate their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation. It is also included in the annual in-service education programme (2013 education schedule sighted). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). The four relatives and six residents report on interview that they are treated with respect and understand their rights. |

##### **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:** |
| Dementia and Rest Home: The Code of Health and Disability Services Consumers' Rights (the Code) is included in the Resident Information Pack. The Information Pack is given to all residents and family/whanau before or at the time of admission. Brochures on the Code and advocacy services are displayed at the entrance to the facility. The Code poster is located in a visible location. Resident and family interviews confirm the residents' rights are upheld by staff. The staff report on interview their knowledge of residents rights and are able to give examples. |

##### **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:** |
| Dementia and Rest Home: The resident Information Pack identifies that all residents have access to services that promote independence, involvement in decision making, respect of resident rights and promote a safe, comfortable environment. Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with six residents and four family members). Staff report on interview that they understand the need for privacy and express examples of knocking on doors, allowing families time together and residents having choice. Each room has a single bed and evidence is seen of consent being obtained when a resident is in a shared room. The service respects the physical, visual, auditory, and personal privacy of the residents and their belongings at all times. The shared rooms in the rest home have a curtain that divides the rooms down the middle, the rest home residents that live in the shared rooms report that their privacy is maintained. There is a family room for privacy and quiet times.   The relevant Aged Related Residential Care (ARRC) 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:** |
|  |
| **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:** |
|  |
| **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:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a cultural safety policy which provide clear guidelines on providing culturally safe care for Maori residents. The staff report on interview that they attend in-service education on Maori values and beliefs (sighted). Policy includes information on tangi and death of a Maori resident and includes the Code in te reo Maori. Though there is one Maori resident at the time of audit, this resident does not identify as Maori (as confirmed at interview with the care staff and resident). |

##### **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:** |
| Dementia Unit and Rest Home: The residents' ethnic, cultural and spiritual values are assessed on admission to ensure residents receive services that respect their individual values and beliefs. Residents receive services that take into account their cultural and individual values and beliefs. Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided (confirmed in interviews with six residents and four relatives interviewed) and review of satisfaction survey results. Documentation shows evidence of cultural and ethnic individuality being recognised. Staff report on interview they are given education on cultural safety by staff from the Health and Disability Commissioner’s office each year. |

##### **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:** |
| Dementia Unit and Rest Home: Policy identifies that service providers have a list of what comprises serious misconduct that is given to all new staff members. This is included in the staff employment agreement. Staff maintain professional boundaries at all times (observed). There is a Code of Conduct to guide staff (sighted). This provides a set of expectations for behaviour and a framework for disciplinary action. Position descriptions define professional boundaries. Staff report any inappropriate behaviour (confirmed in ten staff interviews). The general manager reports on interview she would action formal disciplinary procedures if there is an employee breach of conduct. |

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

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

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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:** FA |
| **Evidence:** |
| Dementia Unit and Rest Home:  Evidence-based practice is observed, promoting and encouraging good practice (evidenced in interviews with the care staff). Examples include policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with a nurse practitioner and the utilisation of care guidelines for aged care. The service implement the ‘Spark of Life’ person centred approach to care in the specialist dementia unit. The service accesses the residential care education programme through the DHB and the RNs participate in the professional development programme through the DHB. The gerontological nurse specialist and nurse practitioner provide consultation regarding residents who require additional care advice and support.   Evidence is seen on the 2012/2013 education programme that staff are given training annually on all aspects of the resident’s rights and advocacy services. Staff have either completed the National Certificate in the Care of the elderly or are working towards it. This includes the required dementia standards. Evidence is seen in staff files. The GM and clinical staff interviewed report they are given training in house and are given the opportunity to attend off site education sessions.  The six of six rest home residents and four of four family report satisfaction with the quality of care and services. One comment from the family satisfaction survey records that the family felt the service has exceeded their care expectations. |

##### **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:** 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 1.1.9: 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:** |
| Dementia Unit and Rest Home: Staff are identifiable by their name badge. Staff introduce themselves to residents upon entering the resident's room (observed). Evidence of open disclosure is documented on the incident and accident form. It is also documented in the resident's file. Residents and family confirm communication with staff is open and effective (verified in six resident and four family interviews).   Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with six clinical staff (two RN and four caregivers and one general manager).  Family members are frequently used as interpreters, where appropriate and with prior consent. If necessary, an interpreter within the community is sought (confirmed in interview with the general manager). |

##### **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:** |
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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 1.1.9.4 (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:** PA Low |
| **Evidence:** |
| Dementia and Rest Home:  Written consent is obtained where required and evidence is seen in six residents’ files (three dementia and three rest home). Evidence is seen that consent has been gained for outings, photo identification and medication. Informed consent procedures are evaluated, recorded and reviewed to monitor effectiveness. Separate written consents are obtained for disclosure of resident information, restraint use and advance directives. There is an area for improvement relating to the correct documentation for residents with advanced directives.  Residents' choices and decisions are documented in their care plans and acted on (confirmed in six residents’ files and interviews with six residents and four relatives). Verbal consent is obtained prior to an intervention being carried out (confirmed in interview with six residents and four family members). Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process (confirmed in interviews with four caregivers and one general manager). They understand that the consent can be withdrawn at any time (confirmed in interviews with residents and families). |

##### **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:** PA Low |
| **Evidence:** |
| In four of the six files (three rest home and one dementia) reviewed the advanced directive forms do not comply with the standard. The service have two different advance directive forms for CPR used at the service, one for residents who competent to make the informed choice and one for the residents who are assessed as not competent to make the informed decision. The three advanced directive forms for ‘not for CPR’ of residents in the rest home (where the resident is competent), have the CPR form for residents who are not competent and one resident in living in the dementia unit, who is not competent to make the decision, has the form for a competent resident. These forms do reflect the residents choices (as confirmed at interview), though the incorrect form is used for these residents. At the time of audit, the staff did not demonstrate good understanding of variations in the forms and what form to use for competent or not competent residents. |
| **Finding:** |
| In four of the six files (three rest home and one dementia) reviewed the advanced directive forms do not comply with the standard. |
| **Corrective Action:** |
| Ensure residents advance directive forms comply with legislative requirements. Staff undertake education relating to advance directives. |
| **Timeframe (days):** 180 *(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:** |
| Dementia and Rest Home: The Resident Rights Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons (confirmed in interview with six residents and four relatives). The six clinical staff report (four caregivers and two RN) confirm they are given in-service education annually on residents’ rights. |

##### **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:** |
| Dementia and Rest Home: There are telephones available in the lounge area for residents to call family/whanau or receive calls from family/whanau members. There is also a phone adjacent to one of the showers which has large numbers for those with visual impairment. The residents are able to have their own phone in their room should they wish.  Policy includes procedures to be undertaken to assist residents to access community services. Residents are supported if they wish to access community services. Activities include regular outings by van or car (evidenced in interview with the general manager and the activities staff). |

##### **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:** FA |
| **Evidence:** |
| Document review: The complaints management policy sighted complies with right 10 of the Code and the requirements of the standard.   The complaints forms are available as part of the admission process and on display at the entrance to the service. The six of six rest home residents and four of four family/whanau interviewed confirm they are informed about the complaints system and would have no hesitation in raising concerns. The service has a dedicated folder with the complaints and concerns. The folder includes all complaints, dates, and actions taken. The individual complaint and concerns forms have the detailed record of the actions taken. There are a number of minor concerns recorded (eg, feedback on food and the cleanliness of the bathroom in the independent living apartments). The service uses the complaints and concerns feedback as part of the quality improvement plan.   Four caregivers interviewed were all aware of how they are to manage and report complaints. The caregivers advise complaints are uncommon and they are informed by the general manager when a complaint is received.  The general manager advises there have been no complaints to the Ministry of Health (MOH) or Health and Disability Commissioner (H&DC) since the last audit.   The ARRC 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:** 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 1.2: 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:** |
| Document review: The Business and Strategic Plan for 2013-2015 outlines the organisation’s mission, goals, targets, objectives and long term action plan. This was issued in September 2013 and next review date is set for September 2015. The organisation operates services in Matamata and Morrinsville providing rest home and specialist dementia care. The business plan contains strengths, weakness, opportunity and threats (SWOT) and business analysis.  Stage two: The documented mission statement is ‘providing premium rest home and dignified specialist dementia care’. The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed at least two yearly. The Spark of Life approach to care is integrated into the vision, scope and goals of the person centred care in the specialist dementia unit. The general manager reports they have plans to introduce the Spark of Life approach to the rest home service in 2014. The general manager reports to the directors of Kingswood Healthcare at least monthly. The general manager reports that this is often daily. The sighted monthly manager meetings include a report on residents, staff, health and safety, infection control, occupancy and general business.   The service has a general manager with over 20 years’ experience as an administrator and manager in the private hospital setting in South Africa. The manager has six years’ experience as a business manager and in care giving roles in a specialist dementia unit in New Zealand. The general manager is the owner/general manager of another of aged care service in Matamata, and is onsite at Morrinsville at least three times a week. The general manager has over 8 hours experience in the management of care services in the past 12 months. This includes ongoing education and support through the aged care association management network, human resource management, and specific education related to aged care and dementia care. The general manager is responsible for ensuring the overall financial welfare of the service. The sighted job description for the general manager describes the authority, accountability, and responsibility for the overall financial management.   The general manager is supported by a full time registered nurse (RN) for clinical service delivery at the Morrinsville service. The senior RN for the Kingswood organisation is on site when the general manager is at the Matamata service. The facility also has clinical oversight and advice available from a nurse practitioner - confirmed at interview with the nurse practitioner.   The relevant ARRC 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:** |
| The senior RN for the Kingswood facilities and onsite caretaker/caregiver take on the management roles during temporary absences of the general manager. The senior RN job description includes the oversight for both the services of Kingswood Healthcare and the requirements to take on the management duties in temporary absence of the general manager. The senior RN reports that they have had suitable training to take on the general manager’s role during temporary absences and feel that they are also well supported by the nurse practitioner if advice is required for clinical aspects of service delivery. The education records and personal files reviewed evidence ongoing education and professional development.  The relevant ARRC 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:** FA |
| **Evidence:** |
| Document review: The risk management guidelines for 2013-2015 contain the organisation’s objective in quality and risk management. The plan describes the organisation’s commitment to continuous quality improvement. Each part of the service is audited internally, with findings communicated to staff through regular staff meetings. All corrective actions are monitored for effectiveness and reviewed until the best possible outcome is achieved.   Stage two: The sighted quality improvement and risk management guidelines identify objectives and action planning and support to reach identified goals. The overall objective is to meet the needs of all the residents and enhance satisfaction with support/care services and all services they provide. The quality plan covers all aspects of service delivery with actions shown on how to minimise identified risks, who is responsible and the timeframe for implementation. The business risk management plan covers being a good provider, responsible planning, safe environment, and internal audits. The organisation has a quality and risk management system which is understood and implemented by staff; as confirmed at interview with the 10 of 10 staff.   The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meets the requirements of legislation, and are reviewed at regular intervals as defined by policy. Policies are reviewed at least two yearly, or sooner if there are legislative changes. Policies sighted are reflective of good practice and all policies are reviewed by the general managers and senior RN. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff. The footer of each document contains the version control information.   Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. Internal audits sampled for 2013 include building maintenance, food safety, safe environment, infection control, organisational management, care services and waste management. Data is collected for all key performance requirements and analysed and evaluated monthly at the staff and management meetings (minutes sighted). The 10 of 10 staff interviewed report the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meeting and staff communication book/notice board.   Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms are documented and actioned as required to evidence the summary of the event, what has been learned, what actions were taken and why, and the outcome. The corrective actions analysis includes collation, review and actions implemented. A re-audit of the issue is conducted to review if the actions implemented are affective in minimising or eliminating the area of concern. The September analysis records an increase of falls. The analysis includes that the increase is attributed to an individual resident, whose condition has deteriorated and is now receiving palliative care.   Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the facility manager. The risk register is maintained for each area of the service including the independent living apartments. A list is located in each area of the service, for example, the kitchen and medication room. Manual handling and biological hazards, chemical hazards and contractors on site are all recorded.  The relevant ARRC 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:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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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:** 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 1.2.4: 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:** FA |
| **Evidence:** |
| The 10 of 10 staff interviewed demonstrate understanding of the requirements for adverse event reporting. The general manager has an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The general manager reports that there have been no incidents that have required essential notification.   The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. They are reviewed and analysed on a monthly basis. The adverse event forms are used for making improvements where required. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes. The follow up includes a re-audit of the implemented actions to review if the hazard has been controlled or eliminated.   The relevant ARRC 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:** |
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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 1.2.4.3 (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:** 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 1.2.7: 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:** FA |
| **Evidence:** |
| Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for the RNs and the nine GPs who provide medical coverage to the service.   There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The five of five staff files reviewed (one RN, three caregivers and one cook) demonstrate appropriate recruitment and employment processes. With the change of ownership of the business in 2013, new employment contracts for the previous staff are sighted in the staff members’ personnel files. The recruitment and employment process includes advertising, interview process, reference checking, police vetting and qualification validation. The manager reports that potential staff are assessed to ensure they have the positive attributes to enable them to work with the residents living with dementia. There is a performance appraisal system, which is conducted at least annually for all staff (confirmed in the five of five staff files reviewed). The newer staff also have a performance review after the first three months of employment.   New service providers receive an orientation/induction programme that covers the essential components of the service provided. The orientation consists of a checklist, orientation shifts (with includes all shifts), and a handbook with the services key policies and procedures. The orientation covers the services philosophy and vision, code of right, complaints management, staff requirements (eg code of conduct), health and safety, basic care skills, infection prevention and control and food services. The orientation for the staff in the dementia unit includes sessions on implementation of activities, therapies and the management of challenging behaviours. The five of five staff files reviewed evidence an orientation and the 10 of 10 staff interviewed confirmed they received an orientation that was effective in preparing them to work in the service.   A system is in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The ongoing in-service plan for 2013 is sighted. The education provided in 2013 is appropriate to rest home and specialist dementia care. The service provides ongoing education and support of the implementation of the ‘Spark of Life’ philosophy of care in the specialist dementia unit. The service provides support for the staff to complete the Aged Care Education (ACE) national qualifications, which includes the dementia modules. Attendance records are maintained in the education folder and in each individual staff member’s education record. Education conducted over 2013 includes; Spark of Life (multiple session through 2013), management of challenging behaviours (May and September 2013), infection control (May 2013), Consumer rights (July 2013), dementia care (September 2013), elder abuse and neglect prevention (June 2013), palliative care (November 2013). The education programme has specific topics in relation to care of the older person, such as skin care, documentation, manual handling, continence management, pressure are care, wound care, nutrition and communication. The education programme contains the essential and emergency requirements such as fire safety and civil defence response. All staff have a current first aid qualification as confirmed at interview with the general manager, 10 of 10 staff and sighted in the five of five staff files reviewed.   The relevant ARRC 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:** 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 1.2.7.5 (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:** 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 1.2.8: 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:** |
| Document review: The staffing rationale policy identifies that the staff guidelines from the District Health Board are adopted for minimum staffing levels. The management is committed to ensuring that at all times there are adequate numbers of suitably qualified staff to provide timely, safe and appropriate services.  There is a clearly documented and implemented process which determines staffing levels and skill mixes in order to provide safe service delivery and the layout of the service. The rest home and specialist dementia unit are in separate buildings. The service has an onsite caretaker (who is also a caregiver), who lives in accommodation on the grounds and provides after hours care giving support as required. The service also has a five bed independent living facility that is separate from the rest home and dementia building. The general manager reports that care staff do not deliver services to the independent living apartments.   The general manager works across the Kingswood Healthcare’s two facilities and is onsite at Morrinsville at least three times a week. The senior RN from the Kingswood Healthcare facility in Matamata provides support and direction to the full time RN at the Morrinsville facility (Monday to Friday). The full time RN at the Morrinsville service is a newly graduated RN and commenced at the service in May 2013. The service also has clinical guidance and advice from an external nurse practitioner. The full time RN, the RN from the service in Matamata and the onsite caretaker/caregiver provide after hours and on call support to the staff. The full time RN has completed education on dementia care and the management of residents with challenging behaviours. The RN and caregivers can also access afterhours support and advice from the GP practice, a nurse practitioner and an advice call centre at an after-hours medical practice.   The activities coordinator in the dementia unit has completed the dementia unit standards and is working towards completing their diversional therapy qualifications. The activities coordinator has demonstrated knowledge and skills in assessment, implementation and evaluation of diversional and recreational programme. The activities programme incorporates the Spark of Life philosophy in the specialist dementia unit. The care staff in the dementia have completed or enrolled in the required dementia unit standards. The general manager reports that the staff that have not yet completed the unit standards will have these completed within 12 months of employment.   The care staffing for this service includes a full time RN and caregivers for the rest home and dementia services: Rest Home (maximum 17 residents): morning shift 2 caregivers (one 5.45am to 2 pm and one 6am to 1pm); afternoon shift have two caregivers (one 2pm to 10pm and one caregiver 4.30pm to 8pm); and on night shift there is one caregiver (10pm to 6am). There is an activities coordinator in the dementia unit Monday to Friday 9.30am to 3pm.   Dementia Unit (maximum of 12 residents): Morning shift there are two caregivers (one 5.45am to 2pm and one caregiver 6an to 10.30am Monday to Fridays, with this shift finishing time extended to 1pm on weekends); afternoon two caregivers (one 2pm to 10pm and one 4.30pm to 8pm); night shift there is one caregiver 10pm to 6am. A senior caregiver lives onsite and is on call Monday to Friday and every 2nd weekend (they provide assistance to the dementia unit after hours as required). The dementia unit has an activities coordinator 10am to 1.30pm three days a week. The caregivers assist with the 24 hour activities plan in the dementia unit at the times the activities coordinator is not onsite.   There are sufficient kitchen, cleaning and laundry staff to meet the needs of the residents.   The six of six rest home residents and four of four family/whanau (two of these families are of residents who live in the specialist dementia unit) report satisfaction with the skills of the staff and the care provided. The family satisfaction survey from July 2013 has comments such as ‘impressed and touched by the support offered’ and ‘the care is beyond our expectations’.  The relevant ARRC 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:** FA |
| **Evidence:** |
| Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. On admission the admission details and unique identification NHI for each resident is obtained. The six of six residents’ files sighted have accurate and timely information entered into the residents care and administration file. Archived records are stored securely on site, these are retrievable as required. A register is kept of current and past records. The records of past residents are securely destroyed in time frames that complies with legislation.   Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The resident’s files are securely stored in locked staff offices, in both the rest home and speciality dementia unit.   All residents’ records are legible and the name and designation of the service provider is identifiable, as confirmed in the six of six residents files reviewed. The service uses a mix of paper based and electronic assessment and records. The electronic records are password protected and secure log is required to access resident information. All records pertaining to individual residents are integrated, as sighted for the six of six residents files reviewed.  The relevant ARRC 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:** 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 1.2.9.7 (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:** |
| Dementia Unit and Rest Home: An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the service. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative. The six residents and four family members report that prior to admission meetings are held with the general manager regarding the admission agreement to ensure they have full understanding of the requirements. The documentation is given to residents and family and follow up is undertaken with them to ensure they understand the information given. The ten staff interviewed each have a role which they undertake with new residents (eg, the cook meets and explains the menu). |

##### **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:** |
| The general manager reports declining entry rarely occurs as they have close contact with the WDHB referrers and community nurses. The only reason would be a lack of a bed in the required area of care. There is a waiting list for both dementia and rest home care. An enquiry form is completed and held in a folder(sighted). |

##### **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:** |
| Rest Home and Dementia Unit: Service delivery documentation is overseen by the RNs. Documentation is part of the audit process at regular intervals to ensure documentation is reviewed within required timeframes. In the six files reviewed (three rest home and three dementia unit) there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed in the required timeframes.  Kingswood Rest Home uses the interRAI computer programme for assessments and an in-house computer programme for long term care plans. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed. The RNs report there is a process for six monthly multidisciplinary resident review. There is evidence in the six files reviewed (three rest home and three dementia unit) that the family/whanau are invited to attend and sent a copy of the meetings notes following the meeting. Handover at the beginning of each shift is undertaken in the nurses’ station for privacy. Kingswood Rest Home have the services of four GP's who visit twice weekly or at other times if required. They cover on call 24/7 for all residents or an after-hours emergency service is available.  The six clinical staff interviewed (two RNs and four caregivers) report that the Mental Health Services for the Older Person (MHSOP) from the WDHB visit as required and a dietitian is notified for weight loss.  The four relatives interviewed are very positive about the staff, GP and all aspects of care. The six clinical staff interviewed (two RNs and four caregivers) report that they are kept up to date with all clinical changes.  Tracer Methodology Dementia Unit: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*.  Tracer Methodology Rest Home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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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:** FA |
| **Evidence:** |
| Rest Home and Dementia Unit: The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and pain assessment. Referral letters are sighted from external agencies, including WDHB clinics. There is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all six files reviewed (three rest home and three dementia unit) that assessments are conducted on admission and as required. Policy states that service providers will seek appropriate information and access a range of resources to ensure effective assessment processes. In all six files reviewed, the assessment information is used as part of care plan development. Clinical staff document on the care plan progress notes and the individual files if a short term care plan is commenced. The six clinical staff interviewed (two RN, one supervisor and four caregivers) report that they have access to all clinical notes at any time. |

##### **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:** FA |
| **Evidence:** |
| Dementia Unit and Rest Home : The plan of care is discussed with the resident and/or family. In all six files reviewed (three dementia unit and three rest home) evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and mental capacity. All health professionals document in the resident's individual clinical file. Documentation in all six files reviewed includes nursing notes, medical reviews and hospital correspondence. In all six residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. The four families and six residents report they are totally consulted in all aspects of their care. The clinical staff report on interview they are updated at handover, or earlier, of any care changes. |

##### **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:** 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 1.3.5.3 (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:** FA |
| **Evidence:** |
| Dementia Unit and Rest Home: In the six files reviewed (three dementia unit and three rest home) there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents’ desired outcomes are being met. A specific example is a resident who did not like to be showered. There is evidence the clinical staff have implemented a plan to ensure only one staff talks very quietly to the resident during personal hygiene cares and the other stands behind her to assist as needed.  The six clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required. |

##### **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:** 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 1.3.7: 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:** |
| Dementia Unit and rest home: There are two activities coordinators who work at total of 50 hours each a week employed a Kingswood Rest Home. Both of the activity coordinators are new to these roles but have worked as caregivers for several years. They both completed the ACE programme and are commencing the dementia standards in the New Year. Activities are available in the dementia unit and rest home for all residents over seven days.   The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activity coordinators reports that it is important to have activities at similar times each day as the residents get into a routine. This includes morning walks in a group and socialisation within the rest home. They reinforce that physical activities are best in the morning as this is the residents’ more alert times, and just before lunch the coordinator reports she has a sing along to stimulate the residents’ prior to lunch.   External visits for rest home residents include the RSA for lunch, Sunshine Club and art groups. Activities at the facility include sensory games, raised gardens, painting and bird feeding. The Spark of Life philosophy is introduced in the dementia unit and evidence of this is seen. The four relatives and six residents report on interview the activities are positive and include walking and music. |

##### **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:** |
| Dementia Unit and Rest Home: In six of the six files reviewed (three dementia unit and three rest home) evidence is seen of documentation if an event occurs that is different from expected and requires changes to service.  Individual short term care plans are seen for wound care, infections and challenging behaviours. These are kept in an individual folder and each shift documentation is made in the file. These are transferred to progress notes when completed or transferred to the long term care plan.  Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in six of the six files reviewed. Progress notes are signed once a week by RN and each duty by the caregivers. Evidence is seen of the family/whanau involvement in the care reviews. The four relatives report that they receive a copy of the multidisciplinary meeting and are invited to attend.   The six clinical staff interviewed have knowledge of the care plan documentation requirements. |

##### **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:** |
| Dementia Unit and Rest Home: The use of external agencies is available to residents or family should they require them. This includes social workers, advocacy service and WDHB clinics. The four family members report that they are aware of the external agencies if they require them. |

##### **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:** |
| Dementia Unit and Rest Home: There is a discharge or transfer plan if required. Staff identify the services that a resident may require and implement a risk management plan. The four (two rest home and two dementia unit) family members interviewed report that their family member has not been transferred but are confident that this would be managed correctly. |

##### **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:** FA |
| **Evidence:** |
| Dementia Unit and Rest Home: Kingswood Rest Home uses the robotic medicine system whereby medicines are delivered fortnightly except for PRN medication which are delivered as required. When the robotic medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are no controlled drugs in the dementia unit, only in the rest home. All processes comply with the legislative requirements.  There is evidence in all twelve files reviewed (six dementia unit and six rest home) that medication charts are reviewed three monthly by the GP.  There are no standing orders used at this facility.  Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reported that the GP works with the pharmacy but he/she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he charts on the medication sheet. The RNs or a competent caregiver are responsible for medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. The caregiver observed during the lunchtime medicines round followed correct procedures.  There is no self-administration of medicines at Kingswood Rest Home on the day of the audit.  Medicine sheets are signed in ink as required following administration.  Evidence is seen of individual medicines being discussed with the family at the multidisciplinary meeting. |

##### **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:** 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 1.3.13: 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:** FA |
| **Evidence:** |
| Document review: The nutritional and safe food management policies and procedures are based on the Hazard Analysis Critical Control Points (HACCP) approach to food services.   The Food Safety policy identifies that food, fluid and nutritional needs of the resident will be provided in line with recognised nutritional guidelines that are appropriate to the consumer group. Kingswood Rest Home operates a four weekly menu cycle approved by a dietitian (sighted). An individual dietary assessment is completed on admission which identifies individual needs and preferences. Likes are identified as part of the admission assessments. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.  There are two cooks who work over seven days. Both are to update their food safety certificate in 2014 (sighted). Evidence is seen of attendance at annual update on infection control and first aid. The cook reports on interview that she is supported by management on food supplies and listens to residents at the resident meetings on any concerns of requests. Evidence of this is sighted.  If residents require assistance with feeding a caregiver is available to assist and their meal is started earlier. |

##### **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:** 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 1.4: 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:** FA |
| **Evidence:** |
| Document review: The management of waste and hazardous substances policy complies with the requirements of the standard.   Stage two: The laundry has a dirty to clean flow. Protective equipment and clothing (PPE) appropriate to the risks involved when handling waste or hazardous substances is provided and used by the housekeeping staff. The housekeeping supervisor reports that they have had recent education in protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances (last conducted September 2013 and November 2013). Waste management is part of orientation and the external chemical supplier conducts ongoing education.   The ARRC requirements are 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:** 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 1.4.1.6 (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:** FA |
| **Evidence:** |
| The rest home building warrant of fitness expires 4 November 2014. The newly opened dementia unit Certificate of Public Use was issued 12 July 2013, which is valid for 12 months.  All buildings, plant, and equipment comply with legislation. The electrical test and tag was conducted November 2013. The medical equipment calibration was last conducted November 2013. The equipment calibration includes the blood pressure monitors, thermometers and chair scales.   The hot water temperatures are checked in resident areas monthly. The temperatures on the day of audit are above 45 degrees Celsius in two of the resident’s bathrooms. This was addressed at the time of audit, with the tempering values adjusted by the plumbing services to be 45 degrees or below in the resident areas.   There is a planned and ongoing maintenance plan (sighted). The service has an onsite caretaker/caregiver.   The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents at rest home level of care. The rest home and dementia units are in separate buildings, both are fit for purpose for the resident groups.   Residents are provided with safe and accessible external areas that meet their needs. All rooms in the rest home have direct access to the grounds or veranda. The dementia unit provides a safe and fenced outside area for residents to wander freely. Both the rest home and dementia unit have covered outdoor seating areas. The bathing, toilet and outdoor areas in the specialist dementia unit are separated from the rest home level of care residents.  The relevant ARRC requirements are 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:** 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 1.4.2.4 (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:** 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 1.4.3: 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 adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of residents. The 17 bed rest home has one room with an ensuite, toilet, shower and hand basin, there are an additional five toilets and three showers. The 12 bed dementia unit has three toilets and two showers. The bathing and toilet areas in the specialist dementia unit are separated from the rest home level of care residents. Communal toilets and showers are clearly identified by diagrams.   The relevant ARRC requirements are met. |

##### **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:** |
| The rest home has five single rooms and six shared rooms. The shared rooms in the rest home have dividing curtains down the middle of the room. Each of the bed spaces can be accessed through separate doors. The dementia unit has two single rooms and five shared rooms. There is only one door into these rooms and the curtain layout provides adequate privacy for each of the bed spaces. The family/whanau have consented to the shared rooms in the dementia unit (as confirmed in the three of three files reviewed of residents living in the dementia unit). Residents with similar interest and of the same sex are in the shared rooms.   The ARRC 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 manoeuvre 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:** |
| Both the rest home and dementia unit provide safe, adequate, age appropriate areas for relaxation, activities and dining. The rest home has an open plan lounge and dining area that are separated by the furniture layout. There is also external seating and grounds for setting, dining and relaxation. All rooms in the rest home have direct access to the external areas. In the dementia unit the lounge and dining areas are separated. The dementia unit has space for low stimulation areas if the residents do not wish to participate in the activities in the lounge area. The dementia unit has a secure outside area to allow for safe wandering of residents. There are quiet and low-stimulus areas in the specialist dementia unit. A range of activities are provided every day by care staff. These include outings, activities of daily living, creative and physical play and pet therapy (observed on day of audit and confirmed by relative and staff interview). The recreation and dining areas are safe and adequate for use by older person with cognitive impairment.  The ARRC 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:** |
| Document review: The cleaning and laundry service manual 2013 sighted complies with the requirements of the standard.   Stage two: The cleaning and laundry equipment and chemicals are monitored monthly by the external chemical supplier. The six of six rest home residents and four of four family/whanau report satisfaction with the cleaning and laundry services.  The chemicals are stored in the laundry. There are locks on the doors to the laundry to provide secure storage. When the cleaning trolleys are not in use, these are stored in the laundry. There are no cleaning or laundry chemical or equipment stored in the dementia unit. All chemicals sighted are adequately labelled with the suppliers labels.  The ARRC 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:** FA |
| **Evidence:** |
| Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The fire drill was last conducted December 2013 for the dementia unit and November 2013 for the rest home. The earthquake and fire emergency training was last conducted in September 2013.   The approved evacuation plan for the rest home is dated 30 October 1998. The notification for approval of evacuation scheme for the dementia unit is dated 3 December 2013.   Both the rest home and dementia units have a civil defence kit, with adequate food and water for a minimum of three days. The service has a generator, which automatically comes on during power outages. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly by an externally contracted fire safety consultant and these are carried out at different times of the day (records of last fire drill on May 2013). Fire suppression systems are maintained and inspected monthly by an external contractor. The home has closed circuit television recorders in the common areas of both the rest home and dementia unit. The system is used for monitoring a safe/secure environment and reviewing any adverse events (as confirmed at interview with staff and the general manager). The general manager reports that they can monitor the security system when they are off site.   The rest home has a call bell system in all resident areas. There is an audible alert and a light above the room where the call bell is activated. The six of six residents in the rest home report a timely response to the call bells. The dementia unit does not have call bell systems in each resident room. There is a ‘panic call’ bell system that the staff member can call if they need assistance, this rings in the rest home and the onsite caretakers/caregivers accommodation. Where it is required, as assessed for residents living in the dementia unit, there is a bed sensor mat that alerts the staff when a resident is getting out of bed. The four of four staff interviewed in the dementia unit report satisfaction with the call system.   The ARRC requirements are 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:** 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 1.4.7.3 (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:** 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 1.4.7.6 (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:** FA |
| **Evidence:** |
| The internal temperature is monitored monthly. The rest home has central heating in the common areas by air-conditioning/heat pump units, with each room having individual heating, Each room of the rest home has a ranch sliding door to allow for natural light and ventilation. Heat pumps/air-conditioning units are used in the common areas of the rest home for heating and cooling. There is individual heating in the lounge and bed room areas in the dementia unit. All lounge and common areas have at least one window/door for natural light and ventilation. The six of six rest home residents and four of four family/whanau report satisfaction with the light and ventilation.   The ARRC 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:** 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 1.4.8.2 (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:** |
| Document review: The restraint minimisation and safe practice policies comply with the requirements of the standard.   Stage two: There is no recorded restraint or enabler use at the service, as confirmed at interview with the general manager, the RN and four of four caregivers. The restraint register has no recorded restraint or enabler use. As sighted in the services policy if enablers are to be used, they shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety. The dementia unit is in a separate building and has a secure environment with external keypad entry front door, appropriate external fencing and gates on the unit perimeter. Observations at the time of audit evidence that the care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. Staff training in restraint minimisation and strategies for managing challenging behaviour, understanding delirium, confusion and dementia are frequent in-service education topics. Training records show education provided by the clinical manager and external presenters, last conducted in October 2013. The four of four caregivers interviewed demonstrate knowledge on restraint and enabler use and the minimisation of challenging behaviours.   The ARRC requirements are met. |

##### **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:** |
| Document review: The infection control policies and procedures outline the organisation’s aim to prevent and manage the risk of infections and cross infection. The policy documents the organisation’s commitment to providing appropriate resources to ensure the needs of the programme are met. The policy states the programme is reviewed annually and approved by the manager/director. The responsibility for infection control is clearly defined, with clear lines of accountability with the infection control officer’s responsibilities documented in the policy. Infection prevention and control is incorporated into the quality and risk management group.   Kingswood Rest Home has a clearly set out infection control programme that is reviewed annually. The infection control programme has links with the risk management programme implemented by the organisation and is approved.  There is a defined process for gaining advice and support as required. The infection control nurse/co-ordinators report to the staff and general manager on all aspects of Infection Prevention and Control (IPC).  Dementia Unit and Rest Home: Kingswood Rest Home infection control programme identifies that the IPC programme is developed by the RN/IPCC with the assistance of the WDHB IPC expert and the Nurse Practitioner for the Waikato area. Evidence is seen of the programme being reviewed at least annually. The programme is evaluated to assess the progress in achieving the 2012 goals and objectives and establish priorities for 2013 (evidence sighted).  The roles and responsibility for the infection control coordinators is defined in a position description (sighted).Ten staff interviewed confirm that they are required to report residents who are suspected of having infections to the RN promptly. All staff interviewed are able to identify the importance of hand hygiene and using standard precautions. |

##### **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:** |
| Dementia Unit and Rest Home:  In the case of an outbreak, advice will be sought from the GP, laboratory services and experts at the WDHB. The IPCC/RN is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.    Education is also provided by the nurse specialist at WDHB and staff are given the opportunity to attend these in-service education sessions. The ten staff interviewed report good knowledge of infection control, standard precautions and outbreak management. The six residents and four families are informed of any infections and notices are put on the door when required. |

##### **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:** |
| Document review: The infection control policies are based on best practice and are practical and safe to minimise the risk of infections to residents, staff and visitors. The policies are reviewed annually (last conducted September 2013).   Dementia unit and Rest Home: The ten staff (two RNs, four caregivers, two activity coordinator, one house keeper and one cook) report they are informed of any policy changes as part of the education programme. They are also given the opportunity to attend WDHB in-service education sessions on Infection Control. The RN/IPCC attends workshops as provided by the WDHB or NZACA. |

##### **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:** |
| Dementia Unit and Rest Home: Staff orientation covers infection control education relevant to practice within the organisation. Infection prevention and control education was provided to all staff in 2012 and 2013. Ten staff interviewed confirm attending these in-service educations. The education plan for 2013 is sighted and includes infection control sessions.  Education is provided to residents (and/or family members) related to hand hygiene and isolation, if there is an infection outbreak. This is confirmed in interview with residents and families members. |

##### **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:** |
| Dementia unit and rest home: The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy. Policy states that surveillance will be presented at staff meetings. An annual summary of the number and type of infections per month is maintained and sighted for 2013.    A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. The data is entered into the computer each month and reports of surveillance data is presented at monthly staff meetings. The data is benchmarked against national data monthly.  Evidence is sighted of surveillance data from the initial completion of the infection notification form and the process that this becomes part of the quality system. Staff report they are notified of any infections at handover and families are contacted as required. |

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