# Avonlea Trust Board

## Current Status: 11 November 2013

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Avonlea Hospital and Home provides rest home and hospital level care to a maximum of 51 residents (16 hospital and 35 rest home level care). On the days of audit there are 13 hospital level care residents, 36 rest home and one respite resident. Two residents are under the age of 65 years.

There have been no significant changes in the service scope or size since the most recent audit in November 2012 which was to verify the new hospital wing and increase the number of beds available by eight.

This certification audit found no areas requiring improvement and there have been no serious events, police or coroners investigations, and no known complaints to the office of the Health and Disability Commissioner.

## Audit Summary as at 11 November 2013

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 11 November 2013

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

### Organisational Management as at 11 November 2013

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

### Continuum of Service Delivery as at 11 November 2013

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

### Safe and Appropriate Environment as at 11 November 2013

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 11 November 2013

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

### Infection Prevention and Control as at 11 November 2013

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

## Audit Results as at 11 November 2013

### Consumer Rights

There are displays of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and the Health and Disability Advocacy Services in the entrance to the facility. This information is available in several languages and large print if required.

Staff education in relation to the Code and advocacy services is undertaken annually and attendance is compulsory.

The resident and family interviews confirm communication with staff is open and effective. Documentation identifies that all aspects of care and service provision are discussed with the residents and their family prior to, or at the time of admission. Staff interviewed report that they provide adequate time to talk with residents and families. Family or staff members are used as interpreters, if appropriate, with residents and family who have English as second language. If a staff member is not available an interpreter is contacted at Waikato District Health Board.

Residents and relatives are advised on entry to the facility of the complaint process and demonstrated a good understanding of this process during interviews. There have been no external complaint investigations since the previous audit and two internal complaint investigations have been completed and resolved this year.

### Organisational Management

The organisation’s quality and risk management systems are well established and clearly implemented. Short and long term business goals, organisational performance and service delivery is being monitored through internal audits, resident and family feedback and collection of quality data.

Quality outcomes data (eg, results of internal audits, adverse event reporting, health and safety outcomes, infection rates and complaints) is analysed frequently to quickly identify any trends. There is a dedicated quality officer who oversees the monitoring of service delivery, but different staff members also carry out internal audits and contribute to the various committees who meet regularly to discuss and review the care and services being provided.

The adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events and ensure that families or nominated representatives are notified appropriately in a timely manner.

Policies and procedures are kept updated and clearly describe all aspects of service delivery and organisational management.

Staff are recruited and managed according to good employer practices. There is evidence that all new staff complete the orientation programme which contains appropriate and essential information and competency testing. Ongoing staff training is occurring regularly as planned, and subject matters are relevant to the care being delivered. Staffing numbers and the allocation of registered nurses are appropriate for the type of services being delivered. The service has previously struggled to provide 24 hour on site registered nurse cover, but there are now sufficient numbers of registered nurses employed to ensure there is always a registered nurse on site and at least one other on call.

Consumer information is managed in a systematic way and the processes in place meet the requirements of these standards and the NZ Health Records standard.

### Continuum of Service Delivery

Avonlea Hospital and Home has registered nurses and doctors who oversee all assessments, planning and evaluation of service delivery with support from the team leader and nurse manager. The initial nursing assessment is completed within 24 hours of admission and the doctor is available within the required timeframes. The care plans are reviewed as required and clinical risk tools are part of the assessment process and evidence is seen of their usage.

The activities available are appropriate for rest home and hospital level care residents. These include community groups coming to the facility and external visits. The activity staff are working towards Diversional Therapy qualifications as well as National Certificate in the care of the elderly.

Medication management systems comply with current legislation and all clinical staff involved in medicine management receive competency assessment annually. The team leader is responsible for all areas of medication management and works alongside a contracted pharmacy (who overseas controlled drugs and prescribed medication).

Avonlea Hospital and Home employs a cook to oversee the provision of safe nutrition and food standards. She uses a menu which is assessed by a dietitian to ensure nutritional needs are focussed on what residents like, and menu choices are available. Initial dietary assessments identify special dietary requirements and likes and dislikes. Food storage and preparation requirements met the standards. The cook and kitchen staff have completed a safe food handling certificate

### Safe and Appropriate Environment

Avonlea Hospital and Home has a current Building Warrant of Fitness, and although the buildings are older (except for the new hospital wing) these are being maintained to a safe standard. Cleaning and laundry services are provided to a high standard. Chemicals are stored appropriately.

Emergency and disaster planning is evident and equipment and resources are planned, available and well managed. All building regulations, fire safety, emergency and security standards are met. Residents are satisfied with the environment.

### Restraint Minimisation and Safe Practice

The service has clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers are only used to prevent harm and promote independent mobilisation. There are established systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Staff training and competency assessment in safe use of restraint occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. A restraint committee meets every two months to review all matters related to restraint. The committee also conducts regular quality reviews of restraint activity to ensure compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training.

### Infection Prevention and Control

Avonlea Hospital and Rest Home has an infection prevention and control programme which is dated as being reviewed in 2013. There is an Infection Prevention Control (IPC) team who meets monthly and reports to the staff on any issues relating to IPC. There have been no notifiable infections or outbreaks at the facility. Surveillance is occurring for residents who develop infections and these are reported to the IPC team monthly.

# HealthCERT Aged Residential Care Audit Report (version 3.9) for peer review

## **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:** | Avonlea Trust Board |
| **Certificate name:** | Avonlea Trust Board |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | Avonlea Hospital and Home – 52 Ward Street, Taumaranui | | | |
| **Services audited:** | Rest home and hospital, medical. | | | |
| **Dates of audit:** | **Start date:** | 11 November 2013 | **End date:** | 12 November 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:** | 50 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **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 | 20 | Total audit hours | 52 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 13 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 48 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Executive 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:

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

Dated Tuesday, 3 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Avonlea Hospital and Home provides rest home and hospital level care to a maximum of 51 residents (16 hospital and 35 rest home level care). On the days of audit there are 13 hospital level care residents, 36 rest home and one respite resident. Two residents are under the age of 65 years.   There have been no significant changes in the service scope or size since the most recent audit in November 2012 which was to verify the new hospital wing and increase the number of beds available by eight.  This certification audit found no areas requiring improvement and there have been no serious events, police or coroners investigations, and no known complaints to the office of the Health and Disability Commissioner. |

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| **Outcome 1.1: Consumer Rights** |
| There are displays of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and the Health and Disability Advocacy Services in the entrance to the facility. This information is available in several languages and large print if required.   Staff education in relation to the Code and advocacy services is undertaken annually and attendance is compulsory.  The resident and family interviews confirm communication with staff is open and effective. Documentation identifies that all aspects of care and service provision are discussed with the residents and their family prior to, or at the time of admission. Staff interviewed report that they provide adequate time to talk with residents and families. Family or staff members are used as interpreters, if appropriate, with residents and family who have English as second language. If a staff member is not available an interpreter is contacted at Waikato District Health Board.  Residents and relatives are advised on entry to the facility of the complaint process and demonstrated a good understanding of this process during interviews. There have been no external complaint investigations since the previous audit and two internal complaint investigations have been completed and resolved this year. |

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| **Outcome 1.2: Organisational Management** |
| The organisation’s quality and risk management systems are well established and clearly implemented. Short and long term business goals, organisational performance and service delivery is being monitored through internal audits, resident and family feedback and collection of quality data.   Quality outcomes data (eg, results of internal audits, adverse event reporting, health and safety outcomes, infecton rates and complaints) is analysed frequently to quickly identify any trends. There is a dedicated quality officer who oversees the monitoring of service delivery, but different staff members also carry out internal audits and contribute to the various committees who meet regularly to discuss and review the care and services being provided. The adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events and ensure that families or nominated representatives are notified appropriately in a timely manner.  Policies and procedures are kept updated and clearly describe all aspects of service delivery and organisational management.  Staff are recruited and managed according to good employer practices. There is evidence that all new staff complete the orientation programme which contains appropriate and essential information and competency testing. Ongoing staff training is occurring regularly as planned, and subject matters are relevent to the care being delivered. Staffing numbers and the allocation of registered nurses are appropriate for the type of services being delivered. The service has previously struggled to provide 24 hour on site registered nurse cover, but there are now sufficient numbers of registered nurses employed to ensure there is always a registered nurse on site and at least one other on call.   Consumer information is managed in a systematic way and the processes in place meet the requirements of these standards and the NZ Health Records standard. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Avonlea Hospital and Home has registered nurses and doctors who oversee all assessments, planning and evaluation of service delivery with support from the team leader and nurse manager. The initial nursing assessment is completed within 24 hours of admission and the doctor is available within the required timeframes. The care plans are reviewed as required and clinical risk tools are part of the assessment process and evidence is seen of their usage.  The activities available are appropriate for rest home and hospital level care residents. These include community groups coming to the facility and external visits.The activity staff are working towards Diversional Therapy qualifications as well as National Certificate in the care of the elderly.   Medication management systems comply with current legislation and all clinical staff involved in medicine management recceive competency assessment annually. The team leader is responsible for all areas of medication management and works alongside a contracted pharmacy (who overseas controlled drugs and prescribed medication).  Avonlea Hospital and Home employs a cook to oversee the provision of safe nutrition and food standards. She uses a menu which is assessed by a dietitian to ensure nutritional needs are focussed on what residents like, and menu choices are available. Initial dietary assessments identify special dietary requirements and likes and dislikes. Food storage and preparation requirements met the standards. The cook and kitchen staff have completed a safe food handling certificate |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Avonlea Hospital and Home has a current Building Warrant of Fitness, and although the buildings are older (except for the new hospital wing) these are being maintained to a safe standard. Cleaning and laundry services are provided to a high standard. Chemicals are stored appropriately.   Emergency and disaster planning is evident and equipment and resources are planned, available and well managed. All building regulations, fire safety, emergency and security standards are met. Residents are satisfied with the environment. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraint and enablers are only used to prevent harm and promote independent mobilisation. There are established systems and practices for the assessment, approval, monitoring, evaluation and review of any type of restraint. Staff training and competency assessment in safe use of restraint occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency to determine whether there is an ongoing need for the restraint methods in place. A restraint committee meets every two months to review all matters related to restraint. The committee also conducts regular quality reviews of restraint activity to ensure compliance with their policies and to consider all aspects of restraint usage, including the effectiveness and frequency of staff training. |

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| **Outcome 3: Infection Prevention and Control** |
| Avonlea Hospital and Rest Home has an infection prevention and control programme which is dated as being reviewed in 2013. There is an Infection Prevention Control (IPC) team who meets monthly and reports to the staff on any issues relating to IPC. There have been no notifiable infections or outbreaks at the facility. Surveillance is occurring for residents who develop infections and these are reported to the IPC team monthly. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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:** |
| Thirteen of the thirteen staff interviewed and the nurse manager (NM) are able to demonstrate their knowledge of the Code. The Code is included in staff orientation and in the annual in-service education programme (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). Staff observed on the day of the audit all demonstrated knowledge of the Code when interacting with residents.  The seven residents and three relatives interviewed report 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:** |
| This is a test |
| **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:** |
| Opportunities for discussion and clarification relating to the Code are provided to residents and their families (confirmed by interview with the NM). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held as part of the annual education programme (evidence sighted).   The Nationwide Health and Disability Advocacy Services information is included in the Resident Information Pack given prior to or on admission to the service and further information, including contact details, is available to residents and their families at the entrance to the facility (sighted). This information is also given to new residents and their family. |

##### **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:** |
| The residents' safety and abuse prevention policy is comprehensive, provides appropriate definitions of abuse, describes signs of abuse and neglect, different staff roles and responsibilities and prevention strategies. The facility has single rooms (except for one couple room) only and this provides adequate and private areas.   Privacy is maintained by undertaking meetings and discussions in the single rooms. Education on privacy takes place at orientation and during in house education. The thirteen staff and one nurse manager (NM) interviewed understand the residents’ rights to dignity, respect and privacy.  Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with seven of seven residents and three of three family members). Residents are encouraged by staff to be as active as is safely possible (confirmed in interviews with seven residents and three family members). |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is one Maori resident at the time of audit and she reports on interview that she is given all the support and opportunity to follow her Maori values and beliefs with her family. Evidence is seen of education for staff who verbalise on interview the example of the pillow being sacred. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents receive services that take into account their cultural and individual values and beliefs. On-going resident satisfaction surveys monitor this as part the information collected. The one resident of Maori culture and her family are satisfied with the services provided.  Policy identifies that the resident's choice of representative is accepted by the service. Residents are consulted regarding their cultural beliefs and values during their admission. Care plans reflect cultural beliefs and values if identified by the resident and/or family whanau (evidenced in review of seven of the seven residents’ files). Staff receive cultural education at orientation and as a regular in-service education topic. |

##### **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:** |
| Staff report any inappropriate behaviour as confirmed in thirteen staff interviews. The NM will action formal disciplinary procedure if there is an employee breach of conduct (confirmed in interview with the NM). The seven resident and three family interviews report they are comfortable to speak directly to the NM and have no concerns. |

##### **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:** |
| The NM maintains a record of her education and all areas of education are updated. Evidence is seen of regular attendance at the Taumaranui Hospital education sessions which is undertaken using a video link with Waikato District Health Board (WDHB) education system. Evidence is seen of caregivers undertaking regular in-service education which meets all requirements. There is evidence in the annual education plan that education provided to staff ensures a commitment to good practice. The seven staff files reviewed show evidence if education attendance. |

##### **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:** |
| The seven residents and three family confirm communication with staff is open and effective (verified in interviews). There is evidence in the seven files reviewed that family are contacted following incidents (eg, falls) and involved in annual multidisciplinary meetings.  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 nine of nine clinical staff and the NM). There is sufficient space in each single room to permit private discussions.  Processes are identified in the Interpreter Policy. If necessary, an interpreter within the community is sought (confirmed in interview with the NM). |

##### **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:** FA |
| **Evidence:** |
| Written consent is obtained as required and in all seven residents’ files reviewed evidence is seen of consent 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 and restraint use.  Residents' choices and decisions are documented in their care plans and acted on (confirmed in seven of seven residents’ files and interviews with seven residents and three relatives).  Verbal consent is obtained prior to an intervention being carried out (confirmed in interview with seven residents and three 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 thirteen staff and the NM). Staff give a full explanation of the proposed treatment, including any risks, prior to consent being obtained. Written consent is obtained where risk is involved (eg, use of restraint). Staff, residents and their family/whanau understand that consent can be withdrawn at any time (confirmed in interviews with seven residents and three 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:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Residents Rights Policy identifies the consumer'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 seven residents and three relatives). Evidence is seen of inservice education for all staff relating to advocacy and support in the 2103 programme. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two telephones available in the lounge/hall area for residents to call family/whanau or receive calls from family/whanau members. There is also a portable phone which is taken to the residents as required. Interviews with family and residents confirm the ability to contact family and they confirm they are contacted by the provider as needed.  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 with families and community visits to the facility (evidenced in interview with the NM and the activities coordinator). |

##### **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:** |
| The Concerns/Complaints policy provides detailed information about the management of complaints including timeframes and the complainant’s right to seek and independent advocate. The policy states that a copy of the concerns/complaints form is given to residents on admission and is freely available upon request.  There is evidence of investigation, actions and resolution of complaints or concerns. The records of two complaints received in 2013 from two different families provide evidence that complaints are documented, investigated and resolved. Seven residents and three relatives interviewed stated they have been informed about the complaints process, and one of the family members had contributed to the submission of one of the complaints in 2013. This resident was satisfied that the complaint was taken seriously, investigated and that remedial work has been carried out. There was a complaint submitted to the DHB in 2012 regarding the time it took for the family to be notified about a resident’s incident and injury. The DHB investigated, upheld the complaint, issued corrective actions and are now satisfied that the matters are resolved.  The service complies with ARC requirements for D6.2 and D13.3h. |

##### **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 Strategic Plan 2013-2018 contains a mission and vision statement with governance policy and guiding principles. The Operational Plan 2013-2023 contains five year and 10 year goals.  There is evidence the strategic plan and operational plan are formally reviewed annually by the board. The manager reports progress against these plans at two monthly board meetings (minutes sighted)   The facility is managed by a full time employed registered nurse (RN) Manager with support from dedicated staff to manage quality, administration and resident cares. The manager has been in the role for eight years and maintains her nursing portfolio and ongoing professional development. Interview and review of training records shows attendance at local hospital/Waikato DHB seminars for clinical updates, industry seminars for medico legal issues and at least eight hours of training directly related to managing an aged care facility.  The organisation has joined with seven other not for profit trusts who operate aged care facilities in the region. The managers of these services meet six to eight weekly to share resources, conduct bulk purchasing and generally support each other.   The requirements of the Aged Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5 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 trust board has a delegated temporary manager who performs the manager’s role during planned or unexpected absences. This person had previously managed the service and although not a clinician, is suitably qualified in organisational and people management (interview with facility manager and review of records). |

##### **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 quality and risk management plan states that quality improvement will occur through regular review, monitoring and auditing of policies, and contacts, development and use of best practice, cost effective analysis of programmes and the provision of quality standards for all services. There is policy/procedure which describes control of documents, how policies are reviewed to ensure they meet current best practice and the requirements of the NZ Health and Disability Services Standards, regulations and legislation. The reviewed Occupation Health and Safety policy meets the requirements of this standard.  Quality and risk management systems are established and implemented. There is a dedicated quality officer, who is also an enrolled nurse, employed for 16 hours a week. This person carries out regular internal audits on all areas of service delivery. Resident feedback is sought at bi-monthly meetings and through formal surveys of their overall experiences, satisfaction with food services and the activities programme. Families are surveyed annually and their input is also sought at multidisciplinary reviews. Audit outcomes are reported to the trust board and any corrective actions are carried out where deficits are identified, as confirmed by review of board meeting minutes. There is also monthly collation and analysis of infections and incidents. These, along with the audit outcomes data is used to improve service delivery. Quality activities and audit results are communicated to all staff and where appropriate consumers and their families (confirmed by staff interview and observation of notices).   All policies are current and meet best known practice. Review of policy manuals and interview with the manager and quality officer confirm that policies are reviewed with input from other RNs, comparison with the local DHB policies and internet research. Care staff interviewed confirm they are advised of policy changes.  The hazard register is kept updated, health and safety procedures are clearly documented in policy and health and safety matters are discussed at bi-monthly health and safety, quality improvement, staff and board meetings (confirmed by interview with quality officer, manager and four care staff).   The risk management plan describes all known actual and potential risks and mitigating strategies for these.   Residents are regularly assessed (eg, for general risk, incontinence, skin integrity and behavioural assessments) as confirmed by review of seven resident records.  The service complies with 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. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** 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:** |
| DOCUMENT REVIEW: The submitted Incident/Accident-potential hazard policy and procedures define and describe the reporting, documenting, investigation and overall management of adverse events.  The adverse event reporting system is a planned and co-ordinated process. The manager and the board understand their obligations in regards to essential notification reporting (confirmed by interview with the manager and review of board meeting minutes).   Staff document all adverse, unplanned or untoward events on incident forms (confirmed by review of a sample of incident reports and monthly summaries for 2013 and interview with the manager and the quality officer). All incidents are categorised according to subtype (eg, behaviour, falls, and medicine errors). Incident data for 2013 shows that monthly there is on average six falls resulting in no injury, four falls resulting in skin tears, two falls resulting in bruises. There was one minor fracture in March. Medicine errors are mainly failure to sign – nine since January 2013, discarded medicines – nine. There has been one error where a resident was given medicines at the wrong time. There is evidence that all adverse events are investigated to determine a root cause and where possible actions or strategies to prevent recurrence are implemented. Staff are kept informed about falls and other incidents by discussion at staff meetings and through well described information which is displayed in the staff room (sighted). |

##### **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:** |
| There is evidence that staff are recruited and managed in ways that comply with good employer practices (confirmed by review of seven staff files, interview with the RN manager and thirteen staff). All potential employees are police checked, and referees and previous employers are contacted prior to confirmation of employment. Staff files sampled (seven) have accurate and current position descriptions for the roles assigned. The position descriptions describe the tasks/duties responsibilities and authorities of the individual roles. The manager ensures registered nurses and externally contracted professionals have current practising certificates or membership with their professional body as confirmed by interview and sighting of personnel records.  New staff are appropriately oriented to their roles by completing a comprehensive orientation programme that runs over two weeks under the supervision of a buddy. There is separate orientation programme for RNs (confirmed by sample of staff files and staff interview).  Staff training is routinely planned and facilitated (education plan for 2013 and attendance records demonstrate evidence of training attended). Individual written records of staff attendance at education sessions show that all staff have attended at least eight hours per annum as required in the ARC D17.8. Performance appraisals are conducted annually and all seven personnel records contain a record of the most review appraisal. The staff education being delivered is appropriate and related to the care of older people. 50% of caregivers have achieved the National Certificate in Aged Care and all others are encouraged and supported to engage in the Careerforce training to complete the Certificate in Health, Disability and Aged care.   Staff must attend compulsory education in fire and emergency management, manual handling, including use of hoists and lifting, challenging behaviour and restraint, consumer rights, including informed consent and advocacy at least annually. Other regular annual training includes infection control, dementia and confusion, medicines, incontinence, open disclosure, and chemical use. All the RNs and a majority of care staff are trained in resuscitation and first aid. Specific clinical update topics are offered regularly and when required for a particular resident’s cares (eg, congestive heart failure, eye toilets, blood sugars, epilepsy, diabetes, colostomy cares, use of oxygen concentrator, wound care). All registered nurses and senior caregivers who administer medicines are competency assessed in medicines management annually. This is confirmed by review of competency assessments in RN personnel records. |

##### **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 Human Resource policy-staff numbers and skill mix, describes how staff are allocated and/or rostered and that the service regularly evaluates staffing numbers when change occurs (eg, in core business, organisational goals, resident selection criteria, downsize of business or growth).   The service has always struggled with RN cover but there are now seven RNs employed fulltime who share on site and on call duties, plus a part time RN. There is at least one RN on site 24 hours a day seven days a week. The RN Manager is on site for specified hours Monday to Friday and shares the after-hours on call with the clinical leader/ RN so there is an RN on call 24 hours a day seven days a week (24/7) for advice and support. There is a casual pool of caregivers and enough registered nurses employed to provide cover during rostered absences, and a good mix of male and female staff which reflects the resident population.  Morning shifts from 6.45am to 3.15 pm is covered by two RNs an enrolled nurse ( EN) and five caregivers. Afternoon shift 2.45 pm to 11.15 pm is covered by an RN and six caregivers. Night shift is covered by three caregivers and a RN. This is confirmed by review of recent rosters and interview with staff.   Auxiliary staff (eg, administration, cooks, maintenance and the quality officer) work different shifts and are allocated sufficient hours to complete their duties. There are two dedicated cleaners on site every day and two activities co-ordinators who work 36 hours and 27 hours respectively Monday to Friday.   Staff interviewed report that there is an appropriate number of staff on site and that more staff are called in when required. Seven residents interviewed perceive there are enough staff on all shifts to attend to their needs in a timely way. |

##### **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:** |
| There is evidence that consumer information is collected and stored in accordance with the NZ Health Records standard. A consumer file is created prior to admission and essential information is entered on the day of admission (eg, medical conditions, medicines, next of kin and emergency contact numbers, initial assessments and the referral information). The front sheet of the record contains unique personal identifying information, such as the consumers NHI, date of birth, legal name, next of kin, past medical history, presenting medical and physical conditions, allergies/sensitivities, current GP, ethnicity, birthplace, current support needs levels and gender.  There is an electronic resident register/database which is maintained daily.  The current resident records (hard copy) are filed in the main staff office which is locked when not staffed as observed on days of audit. Information from the current files is ‘culled’ every three months and stored in a separate lockable office. Archived records of past or deceased residents are stored in an outside building which is secure and fire protected (inspected).   The seven residents’ records sampled demonstrate that entries are legible and the writer of each entry signs their initials and designation. Records are integrated with information from all disciplines, external providers and medico-legal information. |

##### **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:** |
| An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the home. The NZACA standard Resident's Services Agreement is provided. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative. The seven residents and three family members report that prior to admission meetings are held with the nurse manager (NM) and administrator regarding the admission agreement and they had full understanding of the requirements. The thirteen staff interviewed each have a role 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:** |
| Policy identifies that prospective residents may be refusing entry if at any time the NM feels that an applicant or existing resident is not suitable.The NM reports that family and referral agency will be officially informed with reasons stated for reasons for decline. This process is described in policy and acknowledges that family/whanau and the referral agency are informed of the reason for declining entry to service. The NM reports that they have a close working relationship with the needs assessors at the Tauranamui Hospital and the resident’s suitability for admission is discussed prior to the family visiting. |

##### **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:** |
| On admission all residents are introduced by the NM and admitted by the Clinical leader(CL) The GP contracted to the facility visits within 48 hours of admission for medical and medication assessment or the resident is taken to the medical centre.The CL oversees all care planning, evaluations, and signing off on the documentation. All documentation is reviewed within required timeframes.There is a system in place that identifies all progress notes are to be completed by the RN or caregivers at the conclusion of each duty.This ensures that every resident's progress notes are documented each duty. Clinical risk tools for falls, pressure area and mental capacity are all completed as part of routine admission. Falls are monitored as part of the quality process and any risks identified. These are discussed and actioned at staff meetings and become part of the quality process.  The caregivers attend both in-house education and fifty percent of caregivers have completed the National Certificate in Care of the Elderly through Careerforce (sighted). All seven files( two hospital and five rest home) reviewed show evidence of resident or family/whanau consultation. This includes seven residents and three family members who report during interview that they are consulted regarding their service provision.  Tracer Methodology Rest Home: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology Hospital: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  The required documentation is seen for comfort cares, including pain management and antibiotic use to be assessed at the time.  The nine clinical staff interviewed report that they are given information concerning service delivery at handover and any other time if there is a change in service delivery requirements. Policy states a team approach is taken to ensure service is coordinated.   Evidence is seen of visits from the nurse specialist from WDHB, clinical appointments with specialists as required. |

##### **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:** |
| The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and mental assessment. Referral letters are sighted from external agencies, including WDHB clinics, and there is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all seven(two hospital and five rest home) files reviewed that assessments are conducted within the specified timeframes. Policy states that service providers will seek appropriate information and access a range of resources to ensure effective assessment processes. In all seven files reviewed,( two hospital and five rest home) the assessment information is used as part of care plan development. The clinical staff interviewed report knowledge of clinical tools and when they are to be used. |

##### **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:** |
| In all seven files reviewed 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. Clinical risk tools are used as part of the intervention process and towards measuring achievement of desired outcomes.  All health professionals document in the resident's individual clinical file and have access to care plans and progress notes. Documentation in all seven files reviewed include nursing notes, medical reviews and hospital correspondence. The TL accompanies the doctor on their rounds and documents the outcome in the residents’ progress notes. The GP documents in the computer and sends to the facility to be filed in the residents notes. Evidence is also seen of letters from WDHB clinics. The care plan is written in a language that is user friendly and able to be understood by all staff. Care staff are told of any changes in the care plans at changeover of shifts. In all seven residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. |

##### **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:** |
| In all seven files reviewed there is evidence of the interventions relating to the residents' assessed needs and desired outcomes.The nine clinical staff interviewed report they are informed of all care plan issues at hand over and have relevant in-service education if required.   In all seven residents' files reviewed there is evidence of referrals from the WDHB, including Mental Health Services for the Older Person (MHSOP) and diabetic clinic.The seven residents and three relatives interviewed report that they are satisfied with the external contacts for any health issues and other personnel that are available when required.  The education programme implemented at Avonlea Hospital and Rest Home includes inservice education on diabetes, challenging behaviour and manual handling. |

##### **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:** |
| The activities programme is overseen by the activities coordinator who has worked at the facility for 35 years and an activity assistant who has been employed for one year. The activities coordinator has completed her National certificate in care of the elderly up to the level of advanced dementia level and is commencing diversional training, and the activity assistant is to commence the certificate next year.   Minutes are seen of the residents’ meetings held every two months and follow up of any issues. The activity plan includes cultural days (Maori, Phillipino, African, and Italian), housie, men's BBQ, line dancing, kindergarten and school visits.  The seven residents and three relatives report they enjoy the activites provided and are consulted during one to one on any other equirements. Documentation is all up to date and reviewed. |

##### **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:** |
| Policy requires that an evaluation is undertaken to measure the degree of achievement or response of each resident related to their goals, six monthly. In all seven of the seven files reviewed evidence is seen of the resident's desired outcomes being implemented in the care plans.   When a resident has an event that is different from expected, evidence of this is noted on a short-term care plan. This was noted in two of the seven files reviewed as is appropriate (the other five files had nothing that required a short term plan). This can relate for example, to challenging behaviour, urine and chest infections. If an on-going risk or problem is identified this is then transferred to the long-term care plan. The Team leader (TL) reports she uses the short term care plan and informs staff at handover of the changes and also undertakes relevant education if required. Evidence is seen in the resident's file of a resident with a urine infection. The resident was put on bed rest, given extra fluids and the GP visited and prescribed antibiotics. |

##### **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:** |
| Residents admitted to Avonlea Hospital and Rest Home are given the choice of retaining their own GP or using the GP contracted to the facility. The facility has three GPs who are contracted. One of the GPs was available for interview during the audit and has no concerns relating to the care at Avonlea. The seven residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. The NM reports that residents are given the choice of changing facilities if they are not happy and also if their health needs change. |

##### **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:** |
| The stated objective in policy is that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary as required. The resident's family will be notified of the upcoming appointment and will be invited to attend and assist. Should a resident require transition, exit, discharge or transfer this will be planned and undertaken with the resident and applicable family.   The NM or delegated person, is responsible to ensure that residents are referred to appropriate external services and the transfer process is within policy requirements regarding safety and risk management.The NM and TL report they ensure correct proceedures are followed and family are notified. |

##### **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:** |
| A medication management policy is documented and refers to the processes to be used to prescribe, dispense, administer, review, store, dispose of medications.  Resident’s allergies are established during admission assessment and documented in the medication administration chart. Staff must always check any medication allergies. Any allergies or sensitivities are clearly noted on the medication administration chart. If no allergies are known then this is documented to identify that it has been checked. The standing orders are up to date and comply with legislative requirements.  The policy details how medications are to be stored and includes in the original dispensed packs. Medications are to be stored securely away from moisture and lights (or in a refrigerator if appropriate). There are Controlled Drugs on the premises kept in a locked cupboard accessible when required. A Controlled Drug Register is available and controlled medications processes are up ot date. The blister packs are delivered monthly or earlier if required and each are checked to ensure they are correct with the medication sheet.   The process for reporting medication errors or omissions is detailed within the policy. The process for identifying residents and administering medications is detailed along with documentation responsibilities. The process for documenting standing orders is detailed.   If a resident chooses to self-medicate and has been doing so at home they may do so if assessment (a template is provided) shows that they are capable to do this. The NM assesses a resident’s ability to take their own medication with the GP at least every 3 months or when their physical or cognitive state changes. Self-administration of medication must be noted on the resident's care plan. There is one resident self-medicating on the day of the audit and all requriments are met. Controlled medicine is not self-administered.  There are staff competency assessment processes for oral and other medications, insulin, other injections and warfarin. The NM and qualified caregivers responsible for medicine management have an annual competency review prior to administering medicines.The caregiver was observed during the lunchtime medicines round and correct procedures are followed. Completed assessment forms are seen of caregivers competent to give medication on the day of audit. All seven rest home residents spoken with, report the GP discusses their medicine requirements. All fourteen medication sheets reviewed contain all aspects of the requirements of the medication management policy. |

##### **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:** |
| Avonlea Hospital and Home operate a four week menu cycle. An individual dietary assessment is completed on admission which identifies individual needs and preferences. Evidence is seen of dietitian review of menu every two years.This is carried out in consultation with the family/ whanau as required. Morning and afternoon teas are prepared in the kitchen and there are sandwiches available over 24 hours. The Care Planning policy identifies that the food, fluid and nutritional needs of the resident will be provided in line with recognised nutritional guidelines that are appropriate to the consumer group.  The kitchen staff attend a course for safe food handling every two years - evidence seen in staff files.   In seven of the seven residents’ files reviewed, there is evidence of initial dietary assessment identifying specific needs and the kitchen is notified accordingly. This can include vegetarian diets, diabetic diets or cultural requirements.  The lunch time meal was observed on both days of the audit and residents spoken to are happy with the meals provided. Policy identifies that additional or modified nutritional requirements or special diets are part of the care planning process. 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.  The cook reports that she is always made aware by the NM of any specific dietary requirements for residents. Residents' personal preferences are identified on admission in consultation with the family/whanau. Likes and dislikes are discussed with the staff and as the facility is small, staff are able to identify if the meals are meeting the residents' choices. There are lists on the fridge in the kitchen which identifies special dietary needs, likes and dislikes. The cook and kitchen hand report on interview that they listen to the needs of residents. Up to date cleaning schedule and temperature recordings are sighted. |

##### **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 waste management policy provides general guidelines for appropriate disposal and management of all types of waste including blood and body fluid spills, infectious materials, and sharps. There are also two policies on the management of waste and hazardous substances that discuss provision of PPE, secure storage of chemicals and hazardous substances, using recognised waste management services, disposing of unwanted products safely, using suppliers systems for handling and disposing of chemicals and hazardous substances, having systems in place for reporting and investigating incidents related to hazardous waste, and providing staff education.  Staff receive comprehensive training on all aspects of infection control, including the management of waste and hazardous substances (confirmed by review of six personnel records and interview with care staff, a cleaner and the laundry person).   Staff (eg, cleaning, laundry, kitchen and maintenance personnel) are observed to be using personal protective clothing while carrying out their duties. The ARC 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:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

#### 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:** |
| DOCUMENT REVIEW: The reviewed Transportation of Residents policy contains fully described and detailed information which is directly related to the safe transporting of residents.   Visual inspection and a walk through the facility reveals that the new wing with eight bedrooms and shared ensuites is functioning well. Each of the other five wings has six or eight bedrooms with a single occupant. The rest of the building is older (circa 1960's), with a lot of wood surfaces and high ceilings which present maintenance and cleaning challenges despite daily work. Interviews with two cleaners, maintenance staff, the RN Manager and care staff and review of refurbishment and maintenance records, reveal that all efforts are made to maintain the building’s interior and exterior. There is evidence that plant and equipment is checked regularly, and where indicated, repairs are carried out by authorised service people. On day one of the audit there is water blasting and electrical works being carried out. There is a current building warrant of fitness which expires on 21 August 2014 which is displayed in the entrance to the facility. The amenities, fixtures, handrails, equipment and furniture is suitable for the needs of older people, of a safe design and easily cleaned. The furniture in the dining rooms and the lounges promote ease and comfort for the residents. Residents' bedrooms are an adequate size to accommodate walkers, wheelchairs and other mobility aids. The home is spacious and there are a number of interior and exterior spaces available for residents who do not want to join in group activities. Residents and families interviewed are satisfied with the facility.  The requirements of ARC contract 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:** |
| Residents’ privacy when staff are attending to their personal hygiene needs, is protected by the use curtains and vacant/engaged signs. Each of the five older wings has at least one communal bathroom between eight residents, and two toilets. All are in close proximity to residents’ bedrooms. The new wing has ensuites shared between two bedrooms. Floor surfaces are no slip and there are appropriately situated hand rails and call bells in each bathroom and toilet. There are additional toilets in close proximity to the activites lounge and dining room. There are separately designated visitors and staff bathrooms. All ablutions areas are clearly indicated with signs. Each bedroom has a hand basin and hot water temperature monitoring is in place. There are no resident accessible water outlets with hot water exceeding 35 degrees celsius (sighted temperature monitoring records). |

##### **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:** |
| Visual inspection of the facility reveals there is adequate personal and bed space appropriate for frail elderly residents. Each resident`s bedroom comfortably accommodates furniture and personal belongings and there is enough room to manoeuvre mobility aids. There is adequate space in bathrooms, bedrooms and communal areas for care staff to assist residents. There are four residents who use electric wheelchairs and each has designated space to park the chairs when not in use and/or charge the batteries. Residents interviewed are satisfied with their bedrooms. |

##### **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:** |
| There are separately designated areas for recreation, activities and dining. Residents have ready access to two different lounges where they can relax quietly or meet with their visitors and a large activties room. There are two dining areas. The main dining room which is located close to the kitchen comfortably seats 50 residents and the other smaller room is used by a few hospital level care residents. Residents are satisfied with the communal areas. |

##### **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 laundry management policy contains clear guidelines on laundry design, handling of soiled linen, water temperatures, storage of chemical and staff training. The cleaning policies contain clear descriptions of cleaning procedures, daily and weekly cleaning schedules and chemical safety guidelines.  Bulk cleaning of sheets and towel linen is carried out by an external contractor and there is a laundry staff member designated each day to provide laundry services of residents personal clothing. Two cleaners/laundry staff interviewed explained the cleaning schedule and the cleaners roster. All cleaners are long term employed and very experienced. There are cleaning staff on site seven days per week. Visual inspection of the laundry and the designated cleaners storage cupboard reveals these are kept in a clean and orderly state and are locked when not in use. Chemicals are clearly labelled and spare chemicals are stored appropriately in a locked cupboards. The wall mounted refillable system for the chemicals is situated in the kitchen, cleaners room and the laundry. The washing machine and dryer are checked annually by a contracted electrical service provider. Each wing uses a linen bag system with one for soiled clothing, bed linen and towels and one for other/personal clothing. Material data sheets are available to provide information on all products used at this facility and these are kept in each service area for staff to access if required. The quality officer conducts six monthly audits of cleaning and there is regular feedback sought from residents and their families on the quality and extent of cleaning and laundry. There have been no issues. The requirements of ARC D15.2c, D15.2d, D19.2e 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:** |
| Emergency and security systems are well established and implemented. The service is appropriately staffed by sufficient numbers of people who are educated in emergency responsiveness at all times. Staff are educated about fire and emergency preparedness during orientation and as part of the compulsory in service education. There is a NZ Fire approved evacuation scheme which was reissued in September 2012 after the new wing was built. Trial fire evacuations occur six monthly, and staff atendance at one of these each year is compulsory. The last fire drill occurred on 23 October 2013 (confirmed by review of staff training records, sighted records of drills and correspondence and interview with management and staff). Fire exits are checked twice a week to ensure these are kept clear.   The organisation has documented emergency and disaster plans which are kept in the health and safety manual. The plans comply with all applicable statutory requirements and cover the following emergency situations: fire, hazardous substances, flooding, storms, earthquakes, explosion and hold ups for drugs/money. The manager stated that the Trust Board is committed to the protection of its employees, residents and the facilities from the effects of a disaster, or if that is not possible, minimising such effects. Where possible and practicable the organisation will also provide assistance to the external community and has a verbal agreement with the other aged care facility and the local hospital to support each other in a disaster. The building has back up lighting and a ‘low go’ power system which will maintain life saving equipment. The functionality of these systems is checked monthly by an external contractor. There are generators available in the event of a long term power outage. Staff maintain close links with the Ruapehu District Council Civil Defence officers for this region. Contingency measures are in place in the event of an emergency. Emergency packs are readily available (sighted). The boiler and portabe water sources hold enough water to provide three litres a day for three days for more than 60 people. There is sufficient food stored in the kitchen to feed the same amount of people for a similar time period.   A new call bell system was installed last year when the new wing was built. Staff are observed to be responding to call bells in a timely manner and residents interviewed said they experience staff as quick in turning up.   Staff are responsible for the on site security at night. All windows have security stays and staff check all external doors at dusk to ensure they are locked.  The ARC requirements D15.3e and D19.6 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:** |
| All residents' individual rooms have a window that opens to the outside for ventilation. The residents have a wall mounted radiator in each room. There are also radiators and heat pumps in the dining rooms. There are radiator heaters in the hallways of all wings. There was a concern about the internal temperatures during last summer and a mechanical engineer was consulted. Environmental temperature monitoring is occuring and strategies to reduce the temperatures are being actioned. (confirmed by review of report and observation of the environment). A family member interviewed who expressed concerns about the internal temperatures had not been informed about the preventative measures now in place to moderate any unusual rises in heat. The manager updated the relative on day two of the audit about the strategies in place and the relative was satisfied. Residents interviewed stated they are happy with the internal temperatures during all seasons. |

##### **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: There are fully described restraint policies and procedures.   The service uses bedrails, bib harness, lap belts, and low-low beds as injury prevention methods, but only after full assessment and approval processes have occurred. This is confirmed by review of the restraint register, residents’ records, restraint committee meeting minutes and interview with the restraint co-ordinator and the RN manager.   All restraint interventions are monitored daily and ongoing restraints are formally reviewed at least six monthly. There are five residents who currently require use of single or multiple restraint interventions. Three are using bed rails, four with a bib harness, two with lap belts. There are also four residents who choose to sleep in low low beds and these are not listed as restraints or enablers on the register.   Approval for enabler use is granted following request and signature of consent by the resident and/or family. Enablers are only in use to maximise independence or prevent falls. There is one enabler in use; a resident who owns and installed a half bedrail to assist with sitting up when in bed. |

##### **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.)* |

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Sighted in policy and confirmed by interview with the nurse manager and the quality officer/EN who is the delegated restraint co-ordinator that responsibilities and roles are known and understood. The need for any intervention that restricts movement is assessed by an RN in co-operation with the resident’s registered medical practitioner and perhaps another allied health professional involved in the resident care. Interventions do not occur unless approval has been obtained (evidence confirmed by interview and review of the consent, assessment and approval records of all five residents who use restraints).   The service has managed to remove three sets of bed rails by introducing perimeter guards under bed draw sheets. These work to prevent a resident rolling out of bed. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Clinical risk assessments (eg, falls risk) and a restraint assessment form is completed, which includes all of the criteria as identified in (a) - (h). Five of five restraint files reviewed show full assessments have been conducted. Risks associated with restraint use are documented. Alternative interventions to restraint use are identified and trialled - evidence of this is documented on the assessment sheets. Interviews with the nurse manager and the Quality Officer/restraint co-ordinator demonstrate knowledge and understanding about alternatives, assessment and risks related to restraint use. |

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

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

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

Services use restraint safely

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is evidence that restraint is only applied as a last resort. The need for this is fully assessed, after consideration of alterntatives, and identification of risks associated with the proposed restaint. The intervention is monitored and reviewed to ensure it is clinically indicated, safe, the most appropriate option, and is discontinued when no longer necessary. There is evidence that three residents have had their bed rails removed when reassessment revealed that perimeter guards in their beds were as effective as bed rails but posed no risk to the resident (review of resident records and staff interview). The resident's physical, psychological and cultural issues are taken into account during restraint assessment and use. An up-to-date restraint register is kept (sighted and discussed).   All restraint use is monitored and records are kept when interventions are in use. Review of monitoring records show that two hourly position changes occur for residents who are in bib harnesses or have lap belts when sitting (these were observed to be removed at least every two hours). The resident's GP reviews the need for on-going restraint every six months (evidence of review sighted in five of five residents' files).   There is evidence that all staff attend annual compulsory restraint training and achieve competency in restraint knowledge and implementation. This is confirmed by review of six personnel records and staff interview. The service complies with ARC D5.4n |

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

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two monthly meetings of the restraint committee where each resident who has a restraint intervention is considered and all other matters related to restraint are considered. Evaluation of ongoing restraint is conducted six monthly by the GP and restraint co-ordinator (confirmed by interview). The restraint evaluation documentation sighted includes relevant aspects of this criterion. The frequency of evaluation is dependent on the level of risk associated with the restraint interventon in use (confirmed by review of five resident records, review of restraint committee meeting minutes and interview with manager and restaint co ordinator). |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is evidence that annual reviews and quality audits of restraint occur (sighted records of quality audit in May 2013, in the restraint committee meeting minutes and interviews with the nurse manager and restraint co-ordinator). Monitoring and quality review includes consideration of trends - especially any reduction in use, staff adherance to policy and any changes in practice or policy. |

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

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

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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:** |
| Avonlea Hospital and Rest Home infection control programme identifies that the IC programme is developed by the NM and the Quality Office EN (QO). The NM and the QO share the role of Infection Control Co-ordinator (ICC). The programme is reviewed at least annually. A copy of the annual review of the IC programme, undertaken by the NM and QO, who evaluate the progress in achieving the 2012 goals and objectives and establish priorities for 2013 is sighted.   The roles and responsibility for the infection control coordinator is defined in a position description (sighted). Thirteen of thirteen staff interviewed confirm that they are required to report residents who are suspected of having infections to the NM 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:** |
| In the case of an outbreak, advice will be sought from the GP, laboratory services and Taumaranui Hospital. The NM is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation. The NM and the QO ensure the programme is implemented annually as part of the inservice programme (sighted). Education is also provided by the nurse specialist at WDHB by video link. The thirteen staff interviewed report good knowledge of infection control, standard precautions and outbreak management. The seven residents and three 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 policy and guidelines submitted describe general principles, but no detail on how infection matters are managed in the facility. The guidelines refer to the Bug Control and Infection Prevention and Control manual which will need to be sighted and discussed on site. The guidelines describe the role of the IPC committee, prevention and management of staff infection, staff and resident training and infection outbreak - which refers to the Health Care providers IPC manual.  Thirteen of the thirteen staff interviewed are aware of where the infection prevention and control policies are located. |

##### **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:** |
| Infection prevention and control education was provided to all staff in 2012 and 2013. This included standard precautions and management of incontinence. A record of attendance is maintained and a copy of the presentations held on file (sighted). Thirteen of the thirteen staff interviewed confirm attending this in-service education. 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:** |
| 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 QO imputs this into the computer each month and reports surveillance data to all staff at bi-monthly staff meetings. There are plans to benchmark with other facilities in the area after xmas. The NM reports there has not been an outbreak for 16 years and verbalises the systems that would be implemented if 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.)* |