

Sandringham House Limited

Current Status: 16 January 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance 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

Sandringham House provides rest home level care for up to 21 rest home residents. On the day of the audit there were 16 residents. The owners are supported by a registered nurse with experience in aged care. The organisation has adopted a quality approach towards service delivery and incorporating quality into all aspects of care.

The service has addressed nine of nine shortfalls from the previous certification audit around: complaints and concerns are documented on a complaints register, corrective actions are developed around audit outcomes, initial care plans are completed by the registered nurse and within expected timeframes, aspects of medication management comply with best practice, decanted foods are dated and food temperatures are recorded, hot water temperatures are within expected limits and chemicals are stored securely.

This audit identified one improvement required in relation to medication administration documentation.

Audit Summary as at 16 January 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained

Indicator	Description	Definition
	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 16 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 16 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 16 January 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 16 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 16 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 16 January 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Sandringham House Limited
Certificate name:	Sandringham House Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Sandringham House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 January 2014 End date: 16 January 2014
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit:	16
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Audit Team

Lead Auditor	XXXX	Hours on site	8	Hours off site	4
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	8	Total audit hours off site	6	Total audit hours	14
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Number of residents interviewed	6	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	8	Total number of staff (headcount)	16	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Friday, 14 February 2014

Executive Summary of Audit

General Overview

Sandringham House provides rest home level care for up to 21 rest home residents. On the day of the audit there were 16 residents. The owners are supported by a registered nurse with experience in aged care. The organisation has adopted a quality approach towards service delivery and incorporating quality into all aspects of care.

The service has addressed nine of nine shortfalls from the previous certification audit around: complaints and concerns are documented on a complaints register, corrective actions are developed around audit outcomes, initial care plans are completed by the registered nurse and within expected timeframes, aspects of medication management comply with best practice, decanted foods are dated and food temperatures are recorded, hot water temperatures are within expected limits and chemicals are stored securely.

This audit identified one improvement required in relation to medication administration documentation.

Outcome 1.1: Consumer Rights

Residents and relatives spoke positively about care provided at Sandringham House. Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. Complaints processes are implemented and complaints and concerns are managed and documented. There is a complaints register maintained, this shortfall from previous audit has been addressed and monitored by the service.

Outcome 1.2: Organisational Management

The service has a business plan and quality and risk management plan 2013. Key components of the quality management system link to staff meeting. The service is active in analysing data of audits, infections and incidents. Corrective actions are identified and implemented. The service has made improvements in this area. A 2013 resident satisfaction survey has been completed and there are regular resident/relative meetings. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Outcome 1.3: Continuum of Service Delivery

Sandringham House has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into

care planning and care plan evaluations. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan. Previous shortfall in relation to initial care planning has been addressed. Planned activities are appropriate to the group setting.

There is an appropriate medicine management system in place. The service has addressed shortfalls from previous audit in relation to medicine management and self medicating competencies. There is a new improvement identified at this audit in relation to gaps in documentation of administration of medication. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Food decanted was dated with opening date of product and food temperatures are recorded at time of service. The service has addressed shortfalls in relation to food monitoring.

Outcome 1.4: Safe and Appropriate Environment

The service displays a current building warrant of fitness. The service has addressed previous shortfalls in relation to recording of hot water temperatures at 45 degrees Celsius and safe storage of chemicals.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes definitions of restraint and enablers. The service has remained restraint and enabler free. Staff are trained in restraint minimisation, de-escalation and challenging behaviour.

Outcome 3: Infection Prevention and Control

Infection control data is collated monthly and reported to the staff meeting. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	1	0	0	0
Criteria	0	41	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Of the eight medication signing charts reviewed there was seven that identified gaps in the administration of medications and no explanation as the why they had not	Ensure that medication administration sheets are completed, including a reason if medications not administered e.g. on leave.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				been administered.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy.

Six residents and three family members stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur two monthly and the owner/nurse manager and registered nurse has an open-door policy.

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

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

D16.4b The three family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.

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

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. Complaint in service was provided to staff in April 2013. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. Previous audit identified improvements required by the service in relation to the documenting of all concerns in the complaints register. There is a complaints register identifying three complaints for year 2013, including all documentation pertaining to the issue raised. Therefore this has been addressed. Six residents and three family members advised that they are aware of the complaints procedure and how to access forms.
D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: Sandringham House is managed by a husband and wife team, who recently purchased the business in July 2013. One of the new owners is a registered nurse (and is the nurse manager) has worked previously as a registered nurse at Sandringham and has many years' experience in community nursing. The other works as a handyman and provides administration support. The rest home provides care for up to 21 rest home residents with 16 residents on the day of audit. The service has a current strategic plan and quality plan for 2013/2014. The quality programme is managed by the 'management team'-the two owners and the registered nurse. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The management team meets monthly to assess, monitor and evaluate quality care at Sandringham rest home. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The mission

statement sets out the vision and values of the service: 'to provide a quality homely environment for the elderly whom we have the privilege of looking after in an atmosphere of respect and friendliness which enables them to have their care met regardless of culture, race or creed'.
D15.3d: The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a strategic plan and quality risk management plan that are implemented. There is an internal audit schedule for 2013 and internal audits are completed. Audits for 2013 have been completed with corrective actions documented. This is an improvement since previous audit. Progress with the quality plan is monitored through monthly management/quality meetings, and monthly staff meetings. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Minutes are maintained and easily available to staff. Minutes include actions to achieve compliance where relevant. Discussions with the nurse manager and three care givers confirm their involvement in the quality programme. Resident/relative meetings take place two monthly.

There are implemented health and safety policies that include hazard identification. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The service has extra supplies of food, water and equipment available in the event of a disaster.

There is an infection control manual, infection control programme and corresponding policies which require inclusion of antibiotic resistant infections

There is a restraint minimisation management policy. The service is restraint free.

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

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

A family survey conducted in January 2013 evidences that families are over all very satisfied with the service. A survey evaluation has been conducted with follow up and corrective actions required.

D5.4 The service has the following policies/ procedures to support service delivery;
 D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.
 D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident an hazard management
 D19.2g Falls prevention strategies such as falls assessments, sensor mats, exercise sessions. Falls prevention in-service was provided 26 June 2013.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA

Evidence:

Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at monthly management and staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Incident reports for December 2013 were reviewed. All reports were completed and family notified as appropriate.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA
Evidence: <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (one nurse manager, one registered nurse, two caregivers, one caregiver/cook, one activity person).</p> <p>Advised that reference checks are completed before employment is offered as evidenced in one recently employed staff file reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Three caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in four of four staff files reviewed.</p> <p>Discussion with the owner/ nurse manager and three caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar for 2013, covering all core topics required by ARC contract and other specifics as they arise. The annual training programme exceeds eight hours annually. Twelve caregivers have</p>

recently commenced their level three national certificate in aged care. The nurse manager and registered nurse attends external training including conferences, seminars and sessions provided by the local DHB. Education provided in 2013 included: wound care; pain management; medication, ileostomy and catheter care; infection control; observation and reporting; skin management; restraint; palliative care; emergencies and transfers to hospital; abuse and neglect; code of rights; resuscitation, advance directives and informed consent; complaints; falls prevention, mobility and safe transfers; chemical training; insulin competency; medication competency and death and dying. Fire evacuation drill last conducted October 2013. On review of six staff files, performance appraisals for five files have been completed by the nurse manager or registered nurse and the nurse manager has had her nursing council competencies completed by the other registered nurse.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least one staff rostered on at any one time with one staff on-call. Registered nurse or owner/nurse manager provide first on call. Nurse manager advised that extra staff can be called on for increased resident requirements. Roster includes: Three care givers work 7 -1pm daily, cook/care giver works 7-3.30pm - from 1-3.30pm assists with cares. Caregiver x 1 works 3 - 11pm and care giver x 1 works 11pm - 7am. Registered nurse works 10+ hours per week. Owner/nurse manager and owner are on site 40 hours per week and on-call after hours. Interviews with three caregivers, six residents and three family members identify that staffing is adequate to meet the needs of residents. All staff have completed their first aid certificate and are renewed two yearly.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Care plans are developed by the service's nurse manager or registered nurse who also have the responsibility for maintaining and reviewing care plans. Three family members interviewed confirmed their involvement in the admission and ongoing care planning process. Review of four resident files indicated that these time frames were worked within. Caregivers complete progress notes at the end of each shift, with registered nursing input evident. Short term care plans are completed by the registered nurse for changes in health status. There is an appropriate hand-over briefing between shifts that staff were able to fully describe.

D16.2, 3, 4: The four files reviewed (1. new admission. 2. new admission and high falls risk; 3. resident who self medicates and 4. resident with a wound), identified that in all four files an assessment was completed within 24 hours and all four files identify that the long term care plan was completed within three weeks. This is an improvement from previous audit. There is documented evidence that the care plan were reviewed by the registered nurse and amended when current health changes. All four care plans evidenced evaluations completed at least six monthly.

D16.5e: Four resident files reviewed identified that the general practitioner had seen the resident within two working days. It was noted in resident files reviewed that the general practitioner has assessed the resident as stable and is to be seen three monthly.

A range of assessment tools were completed in resident files on admission and completed at least six monthly including (but not limited to); a) pressure area assessment, b) falls risk assessment, c) dietary needs assessment, d) continence assessment and f) pain assessment as appropriate.

Tracer Methodology:

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

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

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

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

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Care plans are individualised and personalised to reflect needs, goals and outcomes are documented on care plan. Of the four files reviewed, three of those residents were interviewed and all three reported their needs were being appropriately met. The care plan identifies specific care needs for each resident and includes problem/need, objectives, interventions, evaluation for identified issues. Interview with nurse manager verified involvement of families in the care planning process. There were short term care plans in three of four files reviewed and include plans for infections, wounds, skin tears, changes in health status, return from acute care including post-operative care. There was currently no wounds being managed, however archived documentation was evident of wound assessments and management plans are documented. Short term care plans are in use for changes in health status. Three care givers interviewed stated that they have all the equipment referred to in the care plans and necessary to provide care, including wheelchairs, lifting belts, continence supplies, dressing supplies and any miscellaneous items. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p>

Continence management in-service (27 February 2013) and wound management in-service (27 June 2013) have been provided. The nurse manager interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>A range of activities are available and these include the involvement of the residents into the community. The programme reflects resident's interest in the environment and they have choice in their level of participation. Activities include (but are not limited to): (a) outings, (b) exercise programmes, (c) music, (d) crafts, (e) shopping, (f) cooking, (g) reading, (g) games, and (h) entertainment. One-to-one support is provided in situations where residents are unable to participate in group activities.</p> <p>Four of four residents' files sampled demonstrate the individual activities plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Residents' activities assessments were sighted in all four residents' files sampled.</p>

Interviews with the activities coordinator confirm the activities programme meets the needs of the service group and the service has appropriate equipment. Activities are provided for approximately seven hours per week. The week's daily list of activities is displayed on the whiteboard in the dining room. All six residents interviewed confirm their past activities are considered and their enjoyment of the activities they choose to participate in. Family/Resident satisfaction survey completed in January 2013.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All four residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Evaluation are conducted by the nurse manager/registered nurse with input from the resident, family, care staff, activities coordinator and general practitioner. Family are notified of any changes in resident's condition, evidenced in all four residents' files sampled. Residents interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Residents' files evidence referral letters to specialists and other health professionals.

D16.4a Care plans are evaluated at least six monthly and more frequently when clinically indicated.
 D16.3c: All four initial care plans were evaluated by the nurse manager within three weeks of admission.
 D16.3k Short term care plans are in use for changes in health status e.g. infections, wounds, skin tears, changes in health status, return from acute care including post-operative care.
 The general practitioner reviews resident's medical condition and medication charts every three months.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care.

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by general practitioner.

Medication charts record prescribed medications by residents' general practitioner; these are kept in the medication folders. Medication administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication, however there were gaps in the documentation on medication signing sheets with no explanation as to why the medication had not been given.

There is one resident who self-administers medicines. Interview with the resident confirms the resident is aware of the medicines and self-administration timeframes. Patient consent for self-administration of medicines is recorded. There is a three monthly competency assessment conducted by the registered nurse and the resident's general practitioner. Visual inspection of the resident's room evidences medicines are located in a locked draw of the bedside cabinet. Staff check and record medication administration by the resident.

The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded.

There is a medication error/mishap assessment form and procedure in place. In January 2013 there was a large number of medication errors noted. Errors were discussed at staff meeting 30 January 2013 and competencies were repeated. The service reviewed medication errors in February with a decrease in errors reported.

Allergies are identified in residents' medication charts.

There is a staff signature identification sheet (including general practitioner) in the front of the medication folders. There is a controlled drug register, with weekly stock takes by the two registered nurses and six monthly quantity checks occurring. There is currently no residents

receiving controlled medication.

All Staff performing medication administration receive training on medicine management policies and procedures and complete an annual competency testing. Medication in service was provided for all staff in February and September 2013.

Medication audit- April 2013.

D16.5.e.i.2; Eight medication charts reviewed identified that the general practitioner had seen the reviewed the resident three monthly and the medication chart was signed.

A review of the medication systems at Sandringham identifies that the service has addressed shortfalls related to documentation of allergies, checking of controlled drugs, and self-medication processes, however there is a further improvement required in relation to the documentation of administered medications or an explanation as to why not administered.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. Medication Administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term and prn medication, however there were gaps in the documentation on medication signing sheets with no explanation as to why the medication had not been administered.

Finding:

Of the eight medication signing charts reviewed there was seven that identified gaps in the administration of medications and no explanation as the why they had not been administered.

Corrective Action:

Ensure that medication administration sheets are completed, including a reason if medications not administered e.g. on leave.

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

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

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

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

Attainment and Risk: FA**Evidence:**

Food services policies and procedures are appropriate to the service setting. The menu is currently being reviewed by a dietitian, evidence of correspondence with the dietitian was sighted. There are documented protocols for management of residents with unexplained weight loss or gain. Resident's individual dietary needs are identified, documented and reviewed on a regular basis as part of the care plan review. Copies of dietary profiles are located in the kitchen and in residents' files. Additional snacks are available for residents when required. Residents are offered fluids throughout the day. Residents' files sampled demonstrate regular monthly monitoring of individual resident's weight. Residents interviewed were satisfied with the food service provided and report their individual preferences are well catered for and confirm adequate food and fluids are provided. Food is discussed at resident meetings. Food in the kitchen and storage areas are dated, labelled and rotated. Food in the fridges and freezers are stored correctly, dated and covered. Fridge and freezer temperatures are checked and recorded. Food service audit was conducted in February 2013 and family/resident satisfaction survey was conducted in January 2013. Previous audit required improvements whereby decanted foods are dated and food temperatures are monitored, the service has addressed these shortfalls. D19.2 staff have been trained in safe food handling.

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

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

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

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

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

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

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

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

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

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 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

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

Attainment and Risk: FA
Evidence: The building warrant of fitness expires on 23 December 2014. Previous audit identified improvement was required in relation to the provision of hot water at a safe temperature. Water temperature is monitored monthly and records were evidence of temperatures of water to be at 45 degrees Celsius.

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

All buildings, plant, and equipment comply with legislation.

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

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

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

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA
Evidence: Previous audit identified chemicals were not labelled and were not stored securely. These two shortfalls have been addressed by the service. All chemicals reviewed were labelled with manufacturers labels, material safety data sheets were available and there were no chemicals seen in resident areas. Kitchen and laundry areas were locked on inspection.

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The facility was not utilising restraint or enabler use on audit day.

Restraint minimisation, enabler usage and challenging behaviour education was provided in January 2013 and attended by 15 staff. Use of restraint audit was conducted in May 2013 and indicated no restraint use at that time.

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

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

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

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: Infection surveillance is an integral part of the infection control programme and is described in Sandringham's infection control and surveillance policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly management meetings, and monthly staff meetings. If a trend is identified the nurse manager advised the service would respond with an increase in training to staff.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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

