# Forrest Hill Continuing Care Limited

## Current Status: 6 January 2014

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

## General overview

Forrest Hill Home and Hospital provides rest home and hospital level of care services. At the time of audit there were 30 residents (25 hospital and five rest home level of care. The service is reducing their number of residents to 26 in preparation for renovation, construction and extension of the service. There are no areas requiring improvement identified at this audit. One of the strengths of the service, identified at the time of audit, is the clinical direction and support provided by the general manager and clinical coordinator.

## Audit Summary as at 6 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 |
|  | 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 6 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. |

### Organisational Management as at 6 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. |

### Continuum of Service Delivery as at 6 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 6 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. |

### Restraint Minimisation and Safe Practice as at 6 January 2014

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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 6 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. |

## Audit Results as at 6 January 2014

### Consumer Rights

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service. The advocacy service visits every four months for staff education.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services. Evidence is seen of informed consent and open disclosure in residents' files reviewed. Communication channels are clearly defined and interviews and observation confirm communication is effective.

There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

### Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified. The service is managed by an appropriately experienced and qualified general manager who is responsible for the overall service delivery, business administration, quality systems and human resources management.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of rest home and hospital level of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for all staff and education records are well maintained.

Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

### Continuum of Service Delivery

Forrest Hill Home and Hospital has pre-entry and entry services which are organised by the general manager and the registered nurses. These processes are supported by policies and entry information. Included, is the referral process with assessments being performed by the Needs Assessment Co-ordination Service.

The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the general practitioner (GP) along with other health service providers.

Medicines are managed safely and appropriately and meet all legislative requirements. Education and medicine competencies are completed by all staff responsible for the administration of medicines. The medication records reviewed include documentation of allergies and sensitivities.

The activities programme is overseen by one activities co-ordinator who works a total of 36 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.

The food service policies and procedures are appropriate for residents requiring hospital and rest home level care. All resident’s individual needs are identified, documented and choices are available and provided. Meals are well presented, homely and the menu plans have been audited. The residents have a seasonal menu and a contracted dietitian reviewed the menu in February 2012 and is reviewing the menu at the time of audit. Staff have completed appropriate food hygiene education and food hygiene and legislative requirements are met. Positive comments are received on meals as part of the resident satisfaction survey.

### Safe and Appropriate Environment

The service has plans for renovation, construction and extension of the service to increase capacity by 19 beds. At the time of audit the renovation has not commenced, although in preparation, one wing of the service is currently having the residents removed from this wing (either to other beds within the facility or to another aged care service). The service has a transition plan to manage risks during the renovation project. The building has a current building warrant of fitness. The evacuation plan is approved by the fire service.

There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. The laundry service is provided by an externally contracted organisation. The service complies with requirements related to safe and hygienic storage of cleaning and laundry equipment and chemicals.

The building has appropriate systems in place to ensure the residents' physical environment is fit for their purpose. All buildings, plant and equipment comply with legislation. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.

The facility has an appropriate call system for residents to request assistance from staff.

### Restraint Minimisation and Safe Practice

The current approved restraint at the service is the use of bed rails and the locked front door. The service currently has a key coded lock at the front door, with the code is clearly displayed at the key pad that allows for residents and family to freely enter and exit the service. There are two residents with cognitive impairment, where the locked door is assessed as a restraint. There are 10 recorded residents requiring the use of bed rails as restraint and two residents with bed rails as enablers. The services maintains processes for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use. There is a rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. At the time of audit restraint, including enablers is used safely, with ongoing review, assessment and evaluation to ensure restraint is used to maintain safety for the residents. The services demonstrate the monitoring and quality review of their use of restraint.

### Infection Prevention and Control

There is a documented infection prevention and control programme which is approved and facilitated by the general manager and clinical coordinator. All required infection prevention and control policies and procedures are available for staff. These policies have been recently reviewed.

The clinical coordinator, who is the infection prevention and control co-ordinator, participates in relevant ongoing education. Relevant education is also provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurse and caregivers in a timely manner. Overall infection rates and trends are discussed at the monthly staff meetings.

# HealthCERT Aged Residential Care Audit Report (version 3.92)

## **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:** | Forrest Hill Continuing Care Limited |
| **Certificate name:** | Forrest Hill Continuing Care Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification | | | |
| **Premises audited:** | 37 Bond Crescent, Forrest Hill, Auckland | | | |
| **Services audited:** | Rest Home and Hospital | | | |
| **Dates of audit:** | **Start date:** | 6 January 2014 | **End date:** | 7 January 2014 |

**Proposed changes to current services (if any):**

The service has plans to renovate and add a second floor to add 19 new hospital level of care beds. The renovations have not commenced at the time of audit.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 30 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 8 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Monday, 3 March 2014

## **Executive Summary of Audit**

**General Overview**

Forrest Hill Home and Hospital provides rest home and hospital level of care services. At the time of audit there were 30 residents (25 hospital and five rest home level of care. The service is reducing their number of residents to 26 in preparation for renovation, construction and extension of the service. There are no areas requiring improvement identified at this audit. One of the strengths of the service, identified at the time of audit, is the clinical direction and support provided by the general manager and clinical coordinator.

**Outcome 1.1: Consumer Rights**

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service. The advocacy service visits every four months for staff education.   
  
Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services. Evidence is seen of informed consent and open disclosure in residents' files reviewed. Communication channels are clearly defined and interviews and observation confirm communication is effective.   
  
There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

**Outcome 1.2: Organisational Management**

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals for the service are clearly identified. The service is managed by an appropriately experienced and qualified general manager who is responsible for the overall service delivery, business administration, quality systems and human resources management.   
  
The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.   
  
The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery of rest home and hospital level of care. Rosters sighted and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for all staff and education records are well maintained.   
  
Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**Outcome 1.3: Continuum of Service Delivery**

Forrest Hill Home and Hospital has pre-entry and entry services which are organised by the general manager and the registered nurses. These processes are supported by policies and entry information. Included, is the referral process with assessments being performed by the Needs Assessment Co-ordination Service.  
  
The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the general practitioner (GP) along with other health service providers.   
  
Medicines are managed safely and appropriately and meet all legislative requirements. Education and medicine competencies are completed by all staff responsible for the administration of medicines. The medication records reviewed include documentation of allergies and sensitivities.   
  
The activities programme is overseen by one activities co-ordinator who works a total of 36 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.  
  
The food service policies and procedures are appropriate for residents requiring hospital and rest home level care. All resident’s individual needs are identified, documented and choices are available and provided. Meals are well presented, homely and the menu plans have been audited. The residents have a seasonal menu and a contracted dietitian reviewed the menu in February 2012 and is reviewing the menu at the time of audit. Staff have completed appropriate food hygiene education and food hygiene and legislative requirements are met. Positive comments are received on meals as part of the resident satisfaction survey.

**Outcome 1.4: Safe and Appropriate Environment**

The service has plans for renovation, construction and extension of the service to increase capacity by 19 beds. At the time of audit the renovation has not commenced, although in preparation, one wing of the service is currently having the residents removed from this wing (either to other beds within the facility or to another aged care service). The service has a transition plan to manage risks during the renovation project. The building has a current building warrant of fitness. The evacuation plan is approved by the fire service.  
  
There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. The laundry service is provided by an externally contracted organisation. The service complies with requirements related to safe and hygienic storage of cleaning and laundry equipment and chemicals.   
  
The building has appropriate systems in place to ensure the residents' physical environment is fit for their purpose. All buildings, plant and equipment comply with legislation. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.   
  
The facility has an appropriate call system for residents to request assistance from staff.

**Outcome 2: Restraint Minimisation and Safe Practice**

The current approved restraint at the service is the use of bed rails and the locked front door. The service currently has a key coded lock at the front door, with the code is clearly displayed at the key pad that allows for residents and family to freely enter and exit the service. There are two residents with cognitive impairment, where the locked door is assessed as a restraint. There are 10 recorded residents requiring the use of bed rails as restraint and two residents with bed rails as enablers. The services maintains processes for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use. There is a rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. At the time of audit restraint, including enablers is used safely, with ongoing review, assessment and evaluation to ensure restraint is used to maintain safety for the residents. The services demonstrate the monitoring and quality review of their use of restraint.

**Outcome 3: Infection Prevention and Control**

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

## **Summary of Attainment**

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home  
The nine staff interviewed (three RNs, two caregivers, one cook ,one cleaner, one laundry, one activity coordinator) are able to demonstrate their knowledge of the Code of Health and Disability Services Consumers' Rights. The Code is included in staff orientation. It is also included in the annual in-service education programme (2013 education schedule sighted). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names).   
  
The four relatives and five residents report on interview that they are treated with respect and understand their rights.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect **(**HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
The resident Information Pack identifies that all residents have access to services that promote independence, involvement in decision making, respect of resident rights and promote a safe, comfortable environment. Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with five residents and four family members). Staff report on interview that they understand the need for privacy and express examples of knocking on doors, allowing families time together and residents having choice. Each room has a single bed and there are no shared rooms. There are several areas where families can spend time together (both inside and outside).

##### **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.

**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 1.1.3.2 (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.

**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 1.1.3.6 (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.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a Cultural Safety policy which provides clear guidelines on providing culturally safe care for Maori residents. The staff report on interview that they attend in-service education on Maori values and beliefs (sighted). Policy includes information on tangi and death of a Maori resident and includes the Code in Te Reo Maori. There are no Maori residents on the day of the audit.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)**

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
The residents' ethnic, cultural and spiritual values are assessed on admission to ensure residents receive services that respect their individual values and beliefs. Residents receive services that take into account their cultural and individual values and beliefs. Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided (confirmed in interviews with five residents and four relatives interviewed) and review of satisfaction survey results.   
Documentation shows evidence of cultural and ethnic individuality being recognised. Staff report on interview they are given education on cultural safety as part of the in-service education programme.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.8: Good Practice **(**HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
Evidence of open disclosure is documented on the incident and accident form. It is also documented in the resident's file. Residents and family confirm communication with staff is open and effective (verified in five resident interviews and four family interviews).   
  
Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with two caregivers and three RN’s).   
  
Evidence is seen on the 2013 education programme that staff are given training annually on all aspects of the resident’s rights and advocacy services. Evidence is seen of education given by the WDHB Gerontology Nurse as part of the Integrated Residential Aged Care Programme. This includes resident’s rights, promoting independence, aging process and cultural issues. Evidence of this is seen in staff files.  
  
The clinical staff interviewed report they are given training in house and are given the opportunity to attend off site education sessions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Open disclosure policy sighted. The policy provides a definition of open disclosure and the process to be followed in the case of an adverse event. The document includes a policy on interpreter services and the process to be followed. Interpreters are to be accessed where necessary and staff can be used as interpreters.  
  
Stage two: The five of five residents and four of four family/whanau report they have a right to full and frank information and open disclosure from service providers. The incident forms sighted record that the family are notified of the incident/accident. The six of six residents’ files sighted provide evidence of family/whanau communications sheets and where required the general manager has email correspondence with family/whanau that do not live locally. Residents and family members interviewed state they have the opportunity to talk to management or staff.   
  
The ARRC requirements are met.

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.10: Informed Consent **(**HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home Care:   
Written consent is obtained where required and evidence is seen in six residents’ files (four hospital and two rest home) reviewed. Evidence is seen of consent being gained for outings, photo identification and medication. Separate written consents are obtained for disclosure of resident information, restraint use and advance directives.   
  
Residents' choices and decisions are documented in their care plans and acted on (confirmed in six residents’ files and interviews with five residents and four relatives).  
  
Verbal consent is obtained prior to an intervention being carried out (confirmed in interview with five residents and four family members). Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process (confirmed in interviews with two caregivers and three RNs). They understand that the consent can be withdrawn at any time (confirmed in interviews with residents and families).

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

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

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

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons (confirmed in interview with five residents and four relatives). The five clinical staff report (two caregivers and three RNs) confirm they are given in-service education annually on residents’ rights.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Complaints policy and procedure sighted. The document states that a complaint form is easily available to all residents. It describes staff responsibility in the complaint process, provides a complaints flow chart and the template of complaints and compliments used by patients to record complaints or compliments. The complaints procedure describes the time frames in responding to complaints that complies with Right 10 of the Code.  
  
The complaints forms are available as part of the admission process and on display at the entrance to the service. The five of five residents and four of four family/whanau interviewed confirm they are informed about the complaints system and would have no hesitation in raising concerns. The service has a complaints log that includes all complaints, dates, and actions taken. The individual complaint and concerns forms have the detailed record of the actions taken. The complaints log for 2013 records nine complaints, with one of these currently going through the complaints process and not finalised at the time of audit. Three of the three complaints sampled comply with the time frames within Right 10 of the Code.   
  
Four caregivers interviewed are all aware of how they are to manage and report complaints. The caregivers advise complaints are uncommon and they are informed by the general manager when a complaint is received.  
  
The general manager advises there have been no complaints to the Ministry of Health (MOH) or Health and Disability Commissioner (H&DC) since the last audit.   
  
The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: The business, quality, risk and management plan is reviewed annually to identify achieved goals. The documented vision is to offer care of a standard that ensures resident satisfaction by exceeding expectations of quality. The Mission Statement sighted is to provide a quality, homely environment in which frail elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met.  
  
Stage two: The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed at least annually. The direction of the service is set by the directors. There is a weekly directors meeting that discusses and reviews the organisational goals, issues and concerns. The service has two directors, one medical officer based in Auckland and the other is in Christchurch with a human resources background. One of the directors visits and meets with the manager weekly. The minutes sighted for the directors meeting include the quality activities, infection control, health and safety, complaints and results from internal audits. The interview with the director reports that they monitor the reports, quality improvements, complaints and follow up of actions that have been implemented. The director reports that the general manager is suitably qualified to manage the clinical aspects of the service. The director feels that the clinical direction from the general manager and clinical coordinator are strengths of the service.   
  
The general manager is an experienced registered nurse with a current practising certificate. The general manager has previous experience in aged care delivery and the management of health care services (acute care and aged care). The general manager has been in this current role since January 2013. The general manager has attended over eight hours education related to the management of aged care services in the past 12 months. This includes aged care workshops provided by the NZ Health Sector lawyers (July 2013); the general manager is a member of the Care Association of New Zealand and provides ongoing education for aged care management and professional development. The service and general manager are part of the DHB’s “first do no harm” regarding quality improvements for falls management and pressure injuries and first aid. The general manager also attends ongoing education on relevant issues in relation to common conditions in aged care. The manager is currently enrolled in a post graduate diploma in business studies, with a major in human resource development. The general manager’s position description has the responsibilities and authorities for the management of the service. The general manager reports to the directors of the service.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

**Attainment and Risk:** FA

**Evidence:**

The clinical coordinator takes on the role of the general manager during temporary absences. The clinical coordinator commenced their role in August 2013. The clinical coordinator’s job description records that their role includes filling in for the general manager during temporary absences. The clinical coordinator is a registered nurse with over 20 years’ experience in aged are and has held management positions prior to commencing at Forest Hill.  
  
The general manager reports that during an unexpected temporary absence in July/August 2013, the previous clinical coordinator had resigned and a manager from another aged care service and a temporary contract manager were utilised during that temporary absence. The organisation has since employed a new clinical coordinator (RN) who is suitably qualified and experienced to perform the manager’s role during temporary absences.   
  
The relevant ARRC requirements are met.

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

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

**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:**

Stage one: Business, quality risk and management plan sighted, provides information on the risk management strategy of the service. It explains risk and identifies risk levels supplied to the organisation. The Risk management plan sighted identifies risk, who is accountable, start and finish times, methods/resources and status of risk. Each identified risk is given a risk rating. The Health and safety' policy sighted contains the policy, the health & safety officer responsibilities, communication, staff injury policies, security procedures, contractors and subcontractors, hazard management process and hazard registers for different areas, storage of chemicals policy and a template for the notification of uncontrollable events. Each section has detailed information and flow charts for staff use. The goals and objectives include a consumer focus, provision of effective programmes, compliance with certification and contractual requirements, risk management and commitment to continuous improvement. The Control of documents and records policy sighted identifies the document control features required, lists the main documents held by the service, provides information on the review and removal of documents and a document flow chart for new documents.   
  
Stage two: The sighted quality improvement and risk management guidelines identify objectives and action planning and support to reach identified goals. The overall objective is to meet the needs of all the residents and enhance satisfaction with support/care services and all services they provide. The quality plan covers all aspects of service delivery with actions shown on how to minimise identified risks, who is responsible and the timeframe for implementation. The business risk management plan covers being a good provider, responsible planning, safe environment, and internal audits. The organisation has a quality and risk management system which is understood and implemented by staff; as confirmed at interview with the eight of eight staff (three RNs, two caregivers, one cleaner, one laundry worker and one cook).   
  
The policies are developed by an aged care consultant, which the general manager has personalised to the organisation. The policies and procedures are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. Policies are reviewed at least two yearly, or sooner if there are legislative changes. Policies sighted are reflective of good practice and all policies are reviewed by the general managers and clinical coordinator. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.   
  
Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. Internal audits sampled for 2013 include cleaning (January and March), Code of Rights (May), infection control and hand washing (September 2013), Management of Challenging Behaviours (September 2013), care plans (March) annual review of the infection control programme (January) and Health and Safety (October). The general manager interviewed reports the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meeting and reports to the director through weekly meetings.   
  
Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms document the non-conformance, identification of the root cause, proposed actions and quality improvement recommendations, review of the implementation through the quality meeting and are signed off when the recommended actions are implemented. A re-audit of the issue is conducted to review if the actions implemented are affective in minimising or eliminating the area of concern. The service also keeps a corrective action register which records the issues raised, corrective actions, date completed and the review of the actions.   
  
Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the facility manager. The risk register is maintained for each area of the service. The service has developed a risk management plan during the planned renovations, construction and extension of the facility.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The eight of eight staff interviewed demonstrate an understanding of the requirements for adverse event reporting. The general manager has an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The general manager reports that there has been one incident in 2013 that has required essential notification, related to the unexpected absence of the general manager. At this time the DHB were notified and a temporary contract manager was utilised during the absence.   
  
The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. They are reviewed and analysed on a monthly basis. The adverse event forms are used for making improvements where required. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes. The follow up includes a re-audit of the implemented actions to review if the hazard has been controlled or eliminated.   
  
The incidents and accidents are collated, graphed and analysed. Where trends are identified actions are implemented to reduce their occurrence. The October 2013 analysis of the incidents and accident records and increase in falls from the previous month. The analysis records that six falls for the month are attributed to one resident. The actions implemented include medical review, monitoring blood pressure and for infection and medication review. For this resident it is recorded that the bell sensor mat had contributed to increasing falls as the resident tried to avoid standing on the mat. The September 2013 analysis of the incidents and accidents records that falls had significantly reduced and the resident at risk of frequent falls had one fall in November 2013.   
  
The relevant ARRC requirements are met.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Human resources polices sighted provide a process to be followed when employing new staff. It deals with applications, short listing process, interviewing, final decisions and responses to successful and unsuccessful applicants. Templates included are the interview questionnaire, the standard letters and the reference check. Staff induction and orientation policy sighted details a competency based programme for new staff, it covers a policy statement, the procedure for planning the orientation and the buddy for the staff member, the welcome pack and the lists of competencies to be signed off.  
  
Stage two: Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for the RNs, medical practitioners, pharmacy, physiotherapists and podiatrists.   
  
There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The seven of seven staff files reviewed (three RNs, three caregivers and a cook) demonstrate appropriate recruitment and employment processes. The recruitment and employment process includes advertising, interview process, reference checking, police vetting and qualification validation. There is a performance appraisal system, which is conducted at least annually for all staff (confirmed in the seven of seven staff files reviewed). The newer staff also have a performance review after the first three months of employment.   
  
New service providers receive an orientation/induction programme that covers the essential components of the service provided. The seven of seven staff files reviewed evidence an orientation and the eight of eight staff interviewed confirmed they received an orientation that was effective in preparing them to work in the service.   
  
A system is in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The completed annual training time table for 2013 is sighted, as well as the planned education for 2014. The education provided in 2013 is appropriate to rest home and hospital level of care. The education plan includes topics related to the aging process, practical care skills (this is also covered in care staff orientation records sighted), awareness of cultural issues (February 2013), communication (May 2013), observations and reporting (November 2013), promoting independence and recognition of individuality (August 2013) and understanding residents rights/advocacy and informed consent (offered five times in 2013). The service accesses ongoing education through the DHB and hospice. The attendance sheets and individual staff attendance certificates (sighted in the seven of seven staff files) confirms the education and training provided meets the contractual requirements and relevant topics to meet the staff needs. These include restraint minimisation and safe practice (October 2013), management of challenging behaviours (October 2013), infection control (August 2013), first aid/CPR (December 2013), pain management (November 2013), professional boundaries (August 2013) and complaints process (November 2013).   
  
Educational and training is provided relevant to the staff member’s role. The practical care skills includes nutrition and hydration, continence management, personal care and grooming, basic assessment, delirium and dementia, depression, breathlessness and fatigue, depression, nausea and vomiting, catheterisation, syringe driver competency, cardiac issues and stoma care. The cook and kitchen staff have attended safe food handling training. The occupational therapist/activates coordinator attends ongoing care and diversional therapy education and support networks. The housekeeping staff attend ongoing educating on infection control and the use of chemicals.   
  
The five of five residents and four of four family/whanau report satisfaction with the level of skill and ‘caringness’ of the staff at Forrest Hill.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Good employer policy sighted. This document includes a policy statement confirming safe employment. It also includes details and requirements for staffing for management, RNs, caregivers and other specialist staff.   
  
There is a clearly documented and implemented process which determines staffing levels and skill mixes in order to provide safe service delivery and considers the layout of the service. The general manager and clinical coordinator report that they use the safe staffing guidelines and an acuity tool to roster staff numbers based on the needs of the residents.   
  
The general manager (RN) and clinical coordinator (RN) are on duty Monday to Friday and they have an on call roster for clinical advice after hours. The care staffing levels for the service for the current 30 residents (5 rest home and 25 hospital level of care) are confirmed in sighted rosters from 25 November 2013 to 5 January 2013 as:  
morning shift: one RN and five caregivers  
afternoon shift: one RN and four caregivers  
night shift: one RN and two caregivers.   
  
During temporary absence and sick leave, staff are replaced by the organisational staff or agency staff. One the day of audit four of the permanent staff were replaced with agency staff. Over the roster sighted for 25 November 2013 to 5 January 2014 there were 13 times when there are four caregivers on the morning shift as sick leave for caregivers was unable to be replaced (though one RN and four caregiver still meets the minimum contractual staffing requirements for rest home an hospital level of care). The general manager reports that when possible, when agency staff are used, the service accesses a pool of caregivers that have been to the service previously.   
  
There are sufficient kitchen, cleaning and laundry staff to meet the needs of the residents. The occupational therapists/activities coordinator is rostered on morning shift (9am to 3pm) Mondays to Fridays.   
  
The five of five residents and four of four family/whanau report satisfaction with the skills of the staff and the care provided. One resident comment that they are ‘treated like a human being’ by all staff. One resident did comment that they still get good care when agency staff are used, though reports that these staff are not as usually as ‘good’ as the regular staff.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. On admission the admission details and unique identification NHI for each resident is obtained. The six of six residents’ files sighted have accurate and timely information entered into the residents care and administration file. A register is kept of current and past records. The records of past residents are securely destroyed in time frames that comply with legislation.   
  
Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The resident’s files are securely stored in a locked cabinet in the nursing station, with an administration file securely stored at the reception office. Archived records are stored securely on site, these are retrievable as required.  
  
All residents’ records are legible and the name and designation of the service provider is identifiable, as confirmed in the six of six residents files reviewed. The service uses a mix of paper based and electronic assessment and records. The service is in the process of transitioning to the electronic InterRAI assessment and the use of electronic care plans. The electronic records are password protected and secure log in is required to access resident information. All records pertaining to individual residents are integrated, as sighted for the six of six residents files reviewed.  
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Home and Rest Home:   
An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the facility. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative. The five residents and four family members report that prior to admission meetings are held with the general manager regarding the admission agreement to ensure they have full understanding of the requirements. The documentation is given to residents and family and follow up is undertaken with them to ensure they understand the information given. The nine staff interviewed each have a role which they undertake with new residents (eg, the cook meets and explains the menu).

##### **Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)**

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.3.2: Declining Referral/Entry To Services **(**HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The general manager reports decline of entry rarely occurs as they have close contact with the WDHB. The only reason would be usually a lack of a bed in the required area of care. The facility is undergoing a large construction project this year and admissions are on hold at present. An enquiry form is completed and held in a folder (sighted).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:  
Service delivery documentation is overseen by the RNs and is completed and reviewed within required timeframes. In the six files reviewed (two rest home and four hospital) there is evidence of initial assessment, care plans being completed and clinical risk tools being reviewed in the required timeframes.  
  
Forrest Hill Home & Hospital uses the InterRAI computer programme for assessments and an in-house computer programme for long term care plans. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed.  
  
The RNs report there is a process for six monthly multidisciplinary resident reviews. There is evidence in the six files reviewed (two rest home and four hospital) that the family /whanau are invited to attend and sent a copy of the meetings notes following the meeting.   
  
Handover at the beginning of each shift is undertaken in the nurses’ station for privacy. Forrest Hill Home & Hospital have the services of one GP who visits twice weekly or at other times if required. She is on call 24/7 for all residents. The five clinical staff interviewed report (three RNs and two caregivers) that the MHSOP or the Gerontology Specialist Nurse from the WDHB visit as required and a dietician is notified for weight loss, where applicable.  
  
The four relatives interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed (three RNs and two caregivers) report that they are kept up to date with all clinical changes.  
  
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.*

##### **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):**  *(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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.3.4 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
In the six files reviewed (four hospital and two rest home) there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents desired outcomes are being met. The five clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.

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

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

**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 1.3.7: 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:**

Hospital and Rest Home:   
There is one activities coordinator who works full time. She is a qualified Occupational Therapist who specialised in challenging behaviours and dementia care. Activities are available for all residents over seven days. The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents.  
  
During interview the activity coordinators reports that it is important to have activities at similar times each day as the residents get in to a routine. This includes morning walks in a group, socialisation and newspaper reading. They reinforce that physical activities are best in the morning as this is the residents’ ‘alert times’. External visits for residents include shopping and outings to parks. Visits occur often from entertainers, schools, and theme days are well attended. There is a communication sheet which is in different languages if required or a visual page for those residents with hearing disabilities.   
  
The four relatives and five residents report on interview the activities are positive and include walking and music. Evidence is seen of three monthly resident/relative meetings which the activity coordinators coordinate. Minutes are kept and evidence is seen of agenda items being completed or becoming part of the quality plan.

##### **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):**  *(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

**Attainment and Risk:** FA

**Evidence:**

Hospital and rest Home:   
In six of the six files reviewed (two rest home and four hospital) evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. Individual short term care plans are seen for wound care, infections and challenging behaviours. These are kept on a short term care plan and amended as required. These are transferred to the long term care plan if there is an ongoing concern.  
  
Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in six of the six files reviewed. Progress notes are signed once every 24 hours by the RN and each duty by the caregivers. Evidence is seen of the family/whanau involvement in the care reviews. The four relatives report that they receive a copy of the multidisciplinary meeting and are invited to attend.  
  
 The five clinical staff interviewed has knowledge of the care plan documentation requirements.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
There is a discharge or transfer plan if required. Staff identify the services that a resident may require and implement a risk management plan. The four family members interviewed report that their family members have not been transferred to any other health services but are confident that this would be managed correctly.

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

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

**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:** FA

**Evidence:**

Hospital and Rest Home:   
Forrest Hill Home & Hospital uses blister pack medication system whereby medicines are delivered monthly except for PRN medication which is delivered as required. When the blister packs are delivered they are checked by the RN and evidence is seen of the signing sheet. There are controlled drugs in the facility and all processes comply with the legislative requirements.  
  
There is evidence in all twelve files reviewed (four rest home and eight hospital) medication charts reviewed of three monthly reviews by the GP.  
  
There are no standing orders used at this facility.  
  
Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reported that the GP works with the pharmacy but she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and she charts this on the medication sheet.  
  
The RNs are responsible for medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. As the facility has palliative resident all RN’s have competency in the management of a 24 hour pain pump. The RN observed during the lunchtime medicines round followed correct procedures.  
  
There is no self-administration of medicines at Forrest Hill Home & Hospital on the day of the audit.  
  
Medicine sheets are signed in ink as required following administration.  
  
Evidence is seen of individual medicines being discussed with the family at the multidisciplinary meeting.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Food Safety policy identifies that food, fluid and nutritional needs of the resident will be provided in line with recognised nutritional guidelines that are appropriate to the consumer group. Forrest Hill Home & Hospital operates a four weekly menu cycle approved by a dietician (sighted). The dietician is in the process of reviewing the menu at the time of audit. An individual dietary assessment is completed on admission which identifies individual needs and preferences. Likes are identified as part of the admission assessments. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.  
  
There are two cooks who work over seven days. Both are to update their food safety certificate in 2013 (sighted). Evidence is seen of attendance at annual update on infection control and first aid. The cook reports on interview that she is supported by management on food supplies and listens to residents at the resident meetings on any concerns of requests - evidence sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.  
  
If residents require assistance with feeding a caregiver is available to assist and their meal is started earlier.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.3.13.5 (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):**  *(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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Waste management policy sighted complies with requirements of the standard.   
  
Stage two: The laundry has a dirty to clean flow. The laundry is scheduled for refurbishment as part of the construction and renovation programme. Protective equipment and clothing (PPE) appropriate to the risks involved when handling waste or hazardous substances is provided and used by the housekeeping staff. The laundry and cleaning staff interviewed report that they have had recent education in protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances (last conducted September 2013). The service has processes in place for the management of sharps and biomedical waste and spills. Waste management is part of orientation and ongoing education.   
  
The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building warrant of fitness expires on 13 July 2014.   
  
The service has a planned renovation, construction and extension programme to add an additional 19 hospital beds to the service. The service has a comprehensive risk management plan to address potential issues during the renovation and construction. The service is reducing the number of residents to a maximum of 26 during the construction as the renovation will include one wing of the service. The construction has not commenced at the time of audit.   
  
All buildings, plant, and equipment comply with legislation. The electrical test and tag was conducted October 2013 (sighted on equipment and electricians report). The medical equipment calibration was last conducted January 2013 (sighted biomedical verification report from the external service provider). The equipment calibration includes the blood pressure monitors, thermometers, nebulisers, oxygen concentrators, syringe drivers, suction, electric beds, hoists.   
  
The hot water temperatures are checked in resident areas monthly, with the resident area temperature recording 45 degree Celsius or below.   
  
There is a planned and ongoing maintenance plan (sighted). The completed maintenance schedule for 2013 includes laundry equipment, kitchen equipment, door locks, mobility aids, call bells, hoists and all electrical equipment. The maintenance schedule records the maintenance required, frequency and signature when completed.   
  
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents at rest home and hospital level of care.   
  
The relevant ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities **(**HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of residents. All but three of the residents’ rooms have access to either single or shared ensuite facilities. Communal toilets and showers are clearly identified by diagrams. Some of the communal bathrooms have surfaces that are beginning to deteriorate; these rooms are scheduled for renovation and constructions as part of the planned building extension. The five of five residents report satisfaction with the toilet and shower facilities.

##### **Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.4: Personal Space/Bed Areas **(**HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

**Attainment and Risk:** FA

**Evidence:**

All rooms in the facility are single occupancy. Currently there is one dedicated hospital wing (this is due to be renovated as part of the extension) and four wings that can be used for either rest home or hospital residents. Though the rooms are of a smaller proportion in the rest home wings, the manager and three of three RNs and two of two caregivers interviewed report the rooms provide adequate space to allow for mobility aids. Electric beds are available and used for residents who require these (either rest home or hospital level of care). The five of five residents interviewed report satisfaction with their personal space.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The service provides safe, adequate, age appropriate areas for relaxation, activities and dining. There are separate lounges and dining area within the facility. There are decks and courtyards that provide additional recreational space. The five of five residents report satisfaction with the communal area for entertainment, recreation and dining.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Stage one: Laundry services policy sighted includes a job description, the laundry design, procedures to be followed when dealing with linen, laundry equipment and cleaning, infection control principles, chemicals used and first aid. Cleaning services policy sighted includes the job description, the duty schedule and cleaning methods, infection control requirements and other associated information.  
  
Stage two: The cleaning and laundry processes, equipment and chemicals are monitored by the external chemical supplier. The five of five residents and four of four family/whanau report satisfaction with the cleaning and laundry services.  
  
The chemicals are stored in a locked cabinet in the locked laundry when they are not in use. There laundry door has a key coded lock to provide secure storage. When the cleaning trolleys are not in use, these are stored in the laundry. All chemicals sighted are adequately labelled with the suppliers labels.  
  
As the laundry is part of the planned renovation and construction of the service, there is a transition plan to ensure the continuity if the laundry service during the renovation and construction. The service has plans to contract the laundry service to an external provider during the renovation and construction.   
  
The relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The approved evacuation plan for the building is dated 29 June 1994. The service has not commenced renovations at the time of audit and the current evacuation scheme applies. The building is fitted with fire sprinklers, indicator panel and has adequate fire equipment (annual check recorded for March 2013).   
  
The service has a civil defence kit and first aid kits (contents checked at least twice a year, last conducted November 2013). The service has adequate food and water for a minimum of three days. The emergency water supply is currently stored under a stairwell and the service is planning to move the emergency water to a more easily accessible area as part of the planned renovations. The service has a generator, which automatically comes on during power outages. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly by an externally contracted fire safety consultant and these are carried out at different times of the day (records of last fire drill on 12 December 2013). Fire suppression systems are maintained and inspected monthly by the maintenance worker or external contractor.   
  
The service has a call bell system in all resident areas. There is an audible alert and a light above the room where the call bell is activated. The five of five residents and four of four family/whanau report a timely response to the call bells.   
  
The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

An appropriate 'call system' is available to summon assistance when 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 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.8: Natural Light, Ventilation, And Heating **(**HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

The building is heated through individual wall mounted heaters in communal areas and residents rooms. A number of resident rooms have a ranch sliding door to allow for natural light and ventilation, which also provide direct access to the decked areas. All lounge and common areas have at least one window/door for natural light and ventilation. The facility is noted to be well ventilated and at a comfortable temperature at the time of audit. The five of five residents and four of four family/whanau report satisfaction with the heating, light and ventilation.   
  
The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **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:**

Stage one: Restraint minimisation and safe practice policy sighted meets the Standard’s requirements. The policy states that the facility supports a restraint free environment and provides support to staff to enable them to prevent the need for restraint. Safety enablers are permitted to be used at the residents request and to prevent them from falling. There is a detailed procedure outlined for the use of restraint and the documentation requirements. The policy refers to a delegated restraint coordinator and a restraint approval group. Definitions of restraint, types of restraint, enablers, seclusion and de-escalation are provided along with other associated definitions. Staff training requirements are documented. Templates included in the policy are: disturbing behaviour and monitoring form; restraint/enabler pre-assessment form; restraint/enabler risk questionnaire; restraint evaluation form; restraint/enabler register; physical restraint/enabler consent form; restraint monitoring form; consent for the use of enabler; staff competency for the use of restraint/enabler; annual review of restraint use; information for relatives and resident regarding restraint; and the missing resident policy and procedure.  
  
Stage two: The current approved restraint at the service is the use of bed rails and the locked front door. There are 10 recorded residents requiring the use of bed rails as restraint, two residents where the front door is assessed as a restraint. There are two using bed rails as enablers as sighted in the restraint register and confirmed at interview with restraint coordinator (clinical coordinator). As sighted in the services policy if enablers are to be used, they shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety. Staff training in restraint minimisation and strategies for managing challenging behaviour, understanding delirium, confusion and dementia are frequent in-service education topics. Training records show education provided on restraint minimisation and safe use (October 2013) and management of challenging behaviours (October 2013). The service has competency for restraint minimisation and safe use for the care staff, and this is sighted in the care staff files reviewed. The two caregivers interviewed demonstrate knowledge on restraint and enabler use and the minimisation of challenging behaviours.   
  
The service currently has a key coded lock at the front door. The code is clearly displayed at the key pad that allows for residents and family to freely enter and exit the service. The service has two residents with some cognitive impairment that are not able to operate the key code and the assessment process is conducted for these residents as environmental restraint. The restraint process, consent, review, evaluation are followed for these two residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The approved restraints at the service are the use of bed rails, brief support (when sitting in chair) and the coded lock at the front door. At the time of audit the restraints used are bed rails and the coded lock. The restraint coordinator reports that the service has reduced the use of the brief support/lap support. At the time of audit there are 10 residents assessed as requiring the use of bed rails and two of the residents have the locked front door considered as environmental restraint. The service currently has a key coded lock at the front door. The code is clearly displayed at the key pad that allows for residents and family to freely enter and exit the service. The service has two residents with some cognitive impairment that are not able to operate the key code and the assessment process is conducted for these residents as environmental restraint. The restraint, consent, review and evaluation processes are followed for these two residents. The restraint coordinator and general manager report that the coded door is to be removed as part of the renovation project and the service plans to have automatic doors at the entrance.   
  
The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. The resident coordinator approves all restraint use, in conjunction with the GP. If restraint is required there is a restraint risk assessment, restraint assessment, a consent for physical restraint (sighted by the RN, GP and family member). The restraint is reviewed every three months. The care plan records the restraint required, when it is to be applied and monitoring requirements. The three of three RNs and two of two caregivers interviewed confirm their knowledge of the restraint approval process which they fully implement. Once a restraint is approved it is reported at handover and documented in the care plan. Consent from family/whanau, GP and RN is required before restraint is approved.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator reports that restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by identification of triggers, health problems, medications, physical, social or environmental issues. Assessment also considers risk and benefits of restraint or enabler use, such as will it compromise the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm and is there a balance between independence and protection.   
  
The three files reviewed of residents assessed as requiring restraint or enablers identifies that assessments are undertaken for each resident and policy is fully implemented. Assessments are completed by the restraint coordinator or RN. All restraint assessments are updated at least three monthly, with all restraints reviewed at least six monthly through the restraint approval group. The three RNs and two caregivers interviewed demonstrate, understand and implement alternatives to restraint, such as low beds, whenever possible.   
  
The ARRC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator reports that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained.   
  
At the time of audit, bed side rails and the locking of the front door are the restraints used. Restraint planning is undertaken only if the assessment process indicates the use of restraint would be appropriate. Frequent falls by individual residents will often generate commencement of assessment processes and all alternative methods of keeping the resident safe are identified.   
  
Restraint is documented in the resident's file and in the restraint register (sighted). The restraint register records the type of restraint, when approved, review dates and if the restraint is still recommended for user. All enablers and restraint are recorded on the registers and consented to by the family/whanau and the resident as appropriate.   
  
The ARRC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator reports that that all restraint and enabler use is evaluated at least three monthly as part of the resident review process, this is confirmed in the three restraint files reviewed. The evaluation process includes family/whanau and resident input as appropriate. Restraint reviews are reported and discussed at the quality meetings and types of restraints in use are monitored by the quality committee. Documented three monthly reviews sighted in three files identify that assessments are updated as part of the review process to evidence the need for continued restraint or recommendations are made to cease restraint. Care planning is congruent with assessment findings.  
  
Interviews with three RNs and two caregivers confirm they have input into restraint evaluation processes. Family/whanau of one resident who requires restraint (bed rails) confirm they are required to sign on-going consent at each review.   
  
The ARRC requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The monitoring form includes the type of restraint, reason for use, time frames for monitoring, how long the restraint is to remain in use and a record of the checking of the resident. The file review of one resident’s monitoring form indicates two hourly monitoring of the resident when the bed rail is up. The service could benefit from the recording on the restraint monitoring form when the restraint is removed.   
  
The quality review of restraint is part of the quality meeting and there is a specific six monthly review of restraint use at the service. The six monthly review of restraint includes the types of restraint used, the alternatives, if the restraint is used for the least restrictive and minimum amount of time, if policies and procedures are followed, impact of restraint, if the care plan provides information on the restraint use, if the consent forms and evaluation include family/whanau involvement, if staff education is required, review of the restraint registrar and any corrective actions that are required.   
  
The restraint coordinator reports that they have been able to reduce and cease the use of the safety brief restraint for two residents and two other residents are assessed that they no longer require the use of bed rails. Alternatives that are used are low beds. The restraint use is closely linked to the falls reduction programme. All restraints are used for the safety and comfort of the resident. The assessments for the three of three residents’ files reviewed with the use of bed rails indicate that the use of the bed rails is assisting in reducing falls from bed. (See criterion 1.2.4: ‘The September 2013 analysis of the incidents and accidents records that falls had significantly reduced and the resident at risk of frequent falls had one fall in November 2013.’)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Forrest Hill Home & Hospital has a clearly set out infection control programme that is reviewed annually. The infection control programme has links with the quality management programme implemented by the organisation and is approved.  
  
There is a defined process for gaining advice and support as required. The infection control co-ordinator reports to the staff and general manager on all aspects of Infection Prevention and Control (IPC) at monthly staff meetings (evidence sighted of minutes).  
  
Forrest Hill Home & Hospital infection control programme identifies that the IPC programme is developed by the RN/IPCC with the assistance of the WDHB/IPC expert for the WDHB. Evidence is seen of the programme being reviewed at least annually. The programme is evaluated to assess the progress in achieving the 2013 goals and objectives and established priorities for 2014 (evidence sighted).  
  
The roles and responsibility for the infection control coordinator is defined in a position description (sighted). The nine staff interviewed confirms that they are required to report residents who are suspected of having infections to the RN promptly. All staff interviewed are able to identify the importance of hand hygiene and using standard precautions.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.2: Implementing the infection control programme **(**HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
The nine staff (three RN, two caregivers, one activity coordinator, one cleaner, one laundry and one cook) report they are informed of any policy changes as part of the education programme. They are also given the opportunity to attend WDHB in-service on Infection Control. The RN/IPCC attends workshops as provided by the WDHB.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 3.4: Education **(**HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Hospital and Rest Home:   
Staff orientation covers infection control education relevant to practice within the organisation. Infection prevention and control education was provided to all staff in 2012 and 2013 (evidence sighted). This nine 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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)**

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

##### **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.)*