# Pohlen Hospital Trust Board

## Current Status: 11 February 2014

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

## General overview

Pohlen Hospital is a 33 bed facility located in Matamata and provides maternity, medical, surgical, rest home, and hospital level care. There are a total of 18 patients receiving services on the day of audit. There are no patients currently requiring surgical services.

Since the last audit there has been restructuring within the organisation. A new general manager (GM) has been appointed and commenced in December 2013. The nurse manager and clinical nurse leader positions have been replaced with a clinical quality manager (CQM) role. This position is now held by the previous clinical nurse leader.

Renovations have occurred within the maternity unit. The patient rooms have been enlarged and ensuites are now in place for each room and a new birthing pool installed. A sunroom has been added to the main lounge in the hospital area enlarging this area. Flooring and curtains have been replaced. Flat screen televisions have been placed in all patients’ rooms. A new carpark area has been installed.

At the last audit there was one area identified as requiring improvement. This has been addressed. At this audit there are eight areas requiring improvement. This includes: open disclosure; maintaining the complaints register; reviewing policies and procedures; corrective action planning; reviewing the hazard register; and ensuring annual practising certificates and staff performance appraisals are current. Medication standing orders, medication reviews and staff medication competencies are also areas requiring improvement.

## Audit Summary as at 11 February 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 11 February 2014

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

### Organisational Management as at 11 February 2014

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

### Continuum of Service Delivery as at 11 February 2014

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

### Safe and Appropriate Environment as at 11 February 2014

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

### Restraint Minimisation and Safe Practice as at 11 February 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 11 February 2014

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Pohlen Hospital Trust Board |
| **Certificate name:** | Pohlen Hospital |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Unannounced surveillance audit | | | |
| **Premises audited:** | 56 Rawhiti Ave, MATEMATA | | | |
| **Services audited:** | Medical, Surgical, Maternity, Geriatric, Rest home care | | | |
| **Dates of audit:** | **Start date:** | 11 February 2014 | **End date:** | 11 February 2014 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 18 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 9.5 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 9.5 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 19 | Total audit hours off site | 12 | Total audit hours | 31 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 12 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 53 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 4 |  |  | Number of GPs interviewed |  |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 26 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Pohlen Hospital is a 33 bed facility located in Matamata and provides maternity, medical, surgical, rest home, and hospital level care. There are a total of 18 patients receiving services on the day of audit. There are no patients currently requiring surgical services.   Since the last audit there has been restructuring within the organisation. A new general manager (GM) has been appointed and commenced in December 2013. The nurse manager and clinical nurse leader positions have been replaced with a clinical quality manager (CQM) role. This position is now held by the previous clinical nurse leader.   Renovations have occurred within the maternity unit. The patient rooms have been enlarged and ensuites are now in place for each room and a new birthing pool installed. A sunroom has been added to the main lounge in the hospital area enlarging this area. Flooring and curtains have been replaced. Flat screen televisions have been placed in all patients’ rooms. A new car park area has been installed.  At the last audit there was one area identified as requiring improvement. This has been addressed. At this audit there are eight areas requiring improvement. This includes: open disclosure; maintaining the complaints register; reviewing policies and procedures; corrective action planning; reviewing the hazard register; and ensuring annual practising certificates and staff performance appraisals are current. Medication standing orders, medication reviews and staff medication competencies are also areas requiring improvement. |

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| **Outcome 1.1: Consumer Rights** |
| Policies and procedures provide guidance for staff on open disclosure and accessing an interpreter. Documentation to demonstrate that open disclosure is occurring for all applicable events is not consistently available and is an area requiring improvement.  Patients, family and staff interviewed are aware of the complaints process. The complaints register for 2013 does not include all complaints and this also is an area requiring improvement. |

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| **Outcome 1.2: Organisational Management** |
| The new general manager (GM) is a registered nurse (RN) and has experience in managing health services. The GM participates in relevant ongoing education. There is a quality and risk programme which is in the process of being reviewed by the GM. The quality and risk programme includes incident reporting, internal audits, patient satisfaction surveys and complaints and compliments management. Staff are informed of relevant issues at shift handover and via staff meetings which have recently become more formalised. Organisation risks have been documented along with strategies to mitigate risks. The hazard register is overdue for review and is an area requiring improvement. Policies and procedures are available to guide staff practice. While work has been undertaken to review and update policies a number of policies are dated as due for review in February 2012. This is also an area requiring improvement. While corrective action plans are being developed when improvements are identified, they are not all sufficiently detailed or, at times, address all applicable areas. Processes to monitor that the required actions have been undertaken and are effective are not consistently occurring. This is an area requiring improvement.   Human resource processes meet current accepted practice with the exception of ensuring applicable staff/contractors hold a current annual practising certificate (APC) and annual staff performance appraisals are undertaken. These are areas requiring improvement. Staff are required to complete an orientation programme. The ongoing education programme is comprehensive and appropriate to the services provided. Records of attendance are maintained. At least one staff member with a current first aid certificate is on duty at all times. Staff providing care in the maternity unit are trained in neonatal resuscitation.  There is at least one registered nurse on duty at all times. Staffing levels and skill mix are planned to meet the needs of patients receiving services. The lead maternity carer (LMC), general practitioner (GP) or nurse practitioner (NP) is on call. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| There are systems and processes developed and implemented to assess, plan and evaluate the care needs of patients in the five services audited. Staff are trained and qualified to perform their roles and deliver all aspects of service provision for the patients in each respective service. Registered midwives and hospital maternity aides are employed to cover the maternity service when patients are in the unit. Lead maternity cares or registered midwives conduct daily checks of the women and their babies. The care plan is developed at thirty six weeks gestation by the lead maternity carer (LMC) which is a LMC responsibility under the Section 88 Access Agreement. For the long term care patients in the hospital registered nurses develop, review, update and evaluate the care plans for the patients at least six monthly, or more frequently as the needs of the patient changes. Care plans reviewed are up to date and reflect current needs of the patients accurately.  The activities programme supports the interests, needs and strengths of patients.  Food service policies and procedures are appropriate to the service settings with a current review by a registered dietitian of the summer and winter menu plans. Patient’s individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection evidences compliance with current legislation and guidelines. Women interviewed in the maternity unit appreciated the choices given for all meals and additional foods are available if and when required. Patients and family/whanau interviewed report satisfaction with the food service provided.  The medication management systems reflect current legislation and guidelines. An appropriate medicines management system is implemented with policies and procedures clearly detailing service providers` responsibilities. There are two areas of required improvement for medication management which relate to standing orders which have not been reviewed in the last year, three monthly medication reviews which are not documented on each patient`s medication records, and medication competency assessments have not been undertaken for all applicable staff in the last twelve months. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current building warrant of fitness. The facility improvements undertaken since the last audit have not required any change to the fire evacuation plan. Bottles of medical gases are now secured securely. The area identified as requiring improvement at the last audit now meets the standard. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The restraint/enabler minimisation and safe practice policy includes the definitions of restraints and enablers. Staff interviewed are able to identify that enablers are required to be voluntary and the least restrictive option. Staff are provided with training on managing challenging behaviour, restraint minimisation and use of enablers as a component of the orientation and ongoing education programme.  At audit there are seven residents who have bedrails in use as an enabler and three residents with restraints in use (either bed rails or a fixed tray). The use of restraint is minimised via use of low beds and sensor mats. The use of restraints, enablers and restraint minimisation strategies are monitored monthly and the use of restraint alternatives noted to be working well as identified in the restraint related documents sighted. |

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| **Outcome 3: Infection Prevention and Control** |
| The service has infection prevention and control policies and procedures relevant to the level of care provided for all services. This manual is used in conjunction with the Bug Control Infection Control Manual which is a resource and reference manual for all aspects of infection control. Professional infection control advisors are able to be consulted as required. The infection prevention and control team appointed consists of the clinical quality manager, an enrolled nurse and a health care assistant. The infection control programme is integrated as part of the quality system and staff receive feedback at their monthly meetings. The education programme reviewed includes training in infection prevention and control. There is evidence of all staff receiving infection prevention and control education as part of the orientation process and this is ongoing. Surveillance is appropriate for the size of the organisation, inclusive of the primary maternity unit. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 31 | 0 | 5 | 3 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | There is an area on the incident report to identify if family have been informed of the event. This is frequently noted as ‘no’ in the incident reports sampled. | Ensure open disclosure consistently occurs and records maintained to verify this. | 180 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The complaints register for 2013 does not include all complaints recieved. Complaints received between August and December 2013 are not on the complaints register. | Ensure the complaints register includes all complaints received, the dates and actions undertaken. | 180 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | While work has been undertaken in 2013 reviewing policies and procedures, thirty one policies are noted to have been due for review in February 2012. | Ensure policies and procedures are reviewed in a timely manner. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Corrective actions plans are not always developed or sufficiently detailed to address all relevant components when areas are identified as requiring improvement. Where plans are developed there is not always evidence that all required actions have been implemented and or monitored for effectivenss. | Ensure sufficiently detailed corrective action plans are developed, implemented and monitored for effectiveness. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.9 | Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | The hazard register has not been reviewed since February 2012. | Ensure the hazard register is reviewed and ammended if required in a timely manner. | 180 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.2 | Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Moderate | 1. One staff member whose annual practising certificate expired on 31 December 2013 is currently working without registration.2. Three of six staff who have been employed for more than 12 months and whose records reviewed are overdue for their annual performance appraisals. The general manager confirms this is a work in progress. | A process is implemented to ensure all registered health professionals that are employed, contracted or hold an access agreement has a current annual practising certificate. Ensure performance appraisals are undertaken annually as required by the organisation and ARRC contract. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | 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. | PA Low | Medication standing orders are overdue for review. They are dated as last reviewed in 2012. The three monthly medication reviews are not documented on the medication records to evidence this has occurred. | Ensure medication standing orders are reviewed at least annually. Ensure documentation evidencing three monthly medication reviews is present on each resident’s individual medication record. | 180 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Medication competency assessments have not been undertaken for all applicable staff in the past twelve months. | Ensure staff administering medications are assessed for competency on at least an annual basis and that this is recorded. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| Policies and procedures detail the process for open disclosure and accessing interpreters. The service cannot evidence that open disclosure is consistently occurring for applicable events and this is an area requiring improvement. The clinical quality manager (CQM) can describe how interpreters are accessed and reports this is a very rare occurrence. All inpatients at audit are able to communicate in English.  The aged related residential care (ARRC) contract requirements are met. |

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| There is an open disclosure policy which supports the rights of patients to be fully informed. The process of open disclosure is documented in the policy sighted.  Three of three hospital aids (HA) interviewed are aware of the policy. The staff advise the RN on duty is responsible for ensuring any required communication occurs with the family. This is confirmed by the RN interviewed.   The incident reports contain an area for staff to document if open disclosure has occurred. This is documented as ‘no’ on the majority of resident related incident reports reviewed selected at random for the period November 2013 to January 2014. This is an area requiring improvement. |
| **Finding:** |
| There is an area on the incident report to identify if family have been informed of the event. This is frequently noted as ‘no’ in the incident reports sampled. |
| **Corrective Action:** |
| Ensure open disclosure consistently occurs and records maintained to verify this. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| There is a compliments and complaints policy which details that patients have the right to make complaints. The process for reproting, investigating and managing complaints is detailed and includes timeframes and meets the requirements of the Health and Disability Commisioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six staff interviewed comprising threee hospital aids (HA), one administrator, one cleaner and one food service employee are able to detail their responsibilities and reproting processes should a patient or family member make a complaint.  The GM is able to detail the processes to be followed to acknowledge and follow-up any complaint received.  Five of five patients and two of two family interviewed are aware of the complaints process. They confirm being happy with services provided.Complaints forms are available and accessible. The complaints register for 2013 does not include all complaints recieved. This is an area requiring improvement.  The GM states he is unaware of any complaints being made to the Ministry of Health and Health and Disability Commissioner. Two complaints are noted in the complaints register related to communication with District Health Board employees. The records summarising the investigations provided a context to the events and most componants of the complaints are not substantiated.  ARRC Contract requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| The complaints register for 2013 does not include all complaints .A complaint received on 15 August 2013 is not on the register. The minutes of quality and safety meetings November 2013 reflected two complaints received. These complaints are not on the complaints register. This is an area requiring improvement.  The GM has developed a new complaints register for 2014 which includes compliments and this is sighted. |
| **Finding:** |
| The complaints register for 2013 does not include all complaints recieved. Complaints received between August and December 2013 are not on the complaints register. |
| **Corrective Action:** |
| Ensure the complaints register includes all complaints received, the dates and actions undertaken. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| An interview with the chairman of the board of trustees (BOT) confirms there has been significant change within the last year. This has included restructuring the management team. Previously a chief executive officer (CEO), nurse manager (NM) and clinical nurse leader (CNL) were employed. Following the restructure a new general manager has been appointed. The GM is a registered nurse (RN) with a current annual practising certificate (APC). The GM has held other management roles within the residential aged care sector as well as other relevant health services. The GM’s curriculum vitae sighted identifies the GM has completed a post graduate diploma in health service management in 2003. The GM has completed at least eight hours training in the last year as required to meet the aged related residential care (ARRC) contract requirements and certificates of completion sighted. The training included privacy, and health and safety topics. The job description for the GM sighted details roles and responsibilities. The GM confirms being responsible for the services provided at Pohlen Hospital. The chair of the BOT confirms the appointment of a GM with a clinical qualification has strengthened a clinical focus to service delivery. While the changes are only recent, the chair of the BOT advises that organisation is moving forward in the right direction.   The previous CNL was appointed to the new role of clinical quality manager (CQM).  Since the GMs employment, a new quality and risk plan has been developed. The draft plan details the scope of the services provided, and notes a quality and risk management focus. The plan includes reference to legislative requirements. Goals and objectives are documented. The draft plan has been presented to the BOT for discussion and approval at the next BOT meeting. This is confirmed by the chair of the BOT.   There is a business strategic plan which includes the organisations vision and values. The plan includes goals and objectives up to 2015 and this is sighted. The GM and chair of the BOT advise once the quality and risk plan has been reviewed and approved by the BOT, the business and strategic plan will then be reviewed. A strategic plan meeting has been scheduled for March 2014. An external facilitator has been appointed for this meeting.   The ARRC contract requirements are met. |

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

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

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

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

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

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

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

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| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| The draft quality and risk management plan sighted includes a number of quality related objectives and includes a focus on quality improvement and effective risk management. The plan details how quality and risk information will be discussed and key information communicated to staff. A quality philosophy is detailed. The process for developing and maintaining policies and procedures is included. The CQM advises a significant amount of work was undertaken in early 2013 reviewing the organisations policies and procedures and these are sighted at audit. A number of policies are noted to have been due for review in February 2012 and have yet to be reviewed. Ensuring timely review of policies and procedures is an area requiring improvement. Electronic master copies of policies are maintained by an administrator. One paper copy is available for staff in the ward office area. The CQM is responsible for ensuring document control processes are implemented.  Patient satisfaction surveys are undertaken. The results are analysed based on which service the patient is accessing and data is graphed. Results of the 2013 satisfaction surveys shows the majority of respondents are positive about the services received. Where feedback recommends/suggests changes these are noted.  Monitoring of compliance with policies and procedures is occurring via the internal audit schedule. Copies of ten audits undertaken in 2013 are sighted during audit. The audits are selected at random and included (but are not limited to) infection control, food services, hand hygiene, civil defence preparedness and documentation. Overall the audit reports demonstrate a high level of compliance with the organisations policies and procedures. Staff interviewed (one cleaner, one catering staff employee, one administrator and three hospital aids) identify they are advised of the outcome of audits that are applicable to their roles. The hospital aids advise they are informed of patient related safety/care issues as a component of shift handovers.   While corrective action plans are normally developed they do not always include all applicable areas requiring improvement. Evidencing that the required improvements have been undertaken and evaluated for effectiveness is not consistently occurring. This is an area requiring improvement.  Quality and risk issues are discussed in the health and safety, quality meetings, registered nurse meetings and staff meetings. The GM has established a new process of monthly meetings which commenced in February 2014. Monthly meetings are scheduled for the health and safety committee, quality committee, and the staff meeting. All staff are required to review and sign that applicable meeting minutes have been read. A folder has been developed for these minutes and contains staff signing sheets with an area for each staff member to sign every month. The minutes of the February 2014 health and safety and quality meeting sighted for the meeting held the day prior to audit. Topics included the number and type of incidents, use of restraints and enablers, infection control information/infection rates, policy and procedure updates, staff training and changes in hazard identification processes. A workplace health and safety representative has been elected by staff. The February 2014 staff meeting occurred on the day of audit. All six staff interviewed confirmed the GM had advertised in advance to staff monthly staff meetingsa re being scheuled and staff are encuouraged to attend. A number of staff sighted attending this meeting on their day off. The minutes of staff meetings held in 2013 could not be located during audit and staff advise the meetings were very infrequent. Meetings of the quality committee for 2013 are sighted and included (but not limited to) policy and procedure review, number and type of incidents and results of internal and external audits.   Organisation risks have been identified along with mitigation strategies. The hazard register is overdue for review. Ths is an area requiring improvement.  The ARRC contract requirements are met excluding D 19.4 b. |

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

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

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

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| While work has been undertaken in 2013 reviewing policies and procedures, 31 policies are noted to have been due for review in February 2012. The CQM and administrator advised with the changes in organisation management and restructuring that occurred in 2013, other work required prioritisation. This is an area requiring improvement. |
| **Finding:** |
| While work has been undertaken in 2013 reviewing policies and procedures, thirty one policies are noted to have been due for review in February 2012. |
| **Corrective Action:** |
| Ensure policies and procedures are reviewed in a timely manner. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| Corrective actions plans are sighted to be developed for all except one complaint received. One complaint received in August 2013 did not have an investigation or a corrective action plan available for review during audit. While actions required to be undertaken are documented on the complaints register, the majority of complaints do not evidence evaluation that the plan has been undertaken and is effective. Corrective action plans are sighted developed following internal audits and incidents. The corrective plans do not always include all relevant components. While on some occasions there is clear evidence the required interventions have been implemented promptly and been effective, this is inconsistent and is an are requiring improvement. Examples include in relation to communication processes and considerations when a patient requires admission to the observation area of the hospital. |
| **Finding:** |
| Corrective actions plans are not always developed or sufficiently detailed to address all relevant components when areas are identified as requiring improvement. Where plans are developed there is not always evidence that all required actions have been implemented and or monitored for effectiveness. |
| **Corrective Action:** |
| Ensure sufficiently detailed corrective action plans are developed, implemented and monitored for effectiveness. |
| **Timeframe (days):**90*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| There is a risk register which is sighted during audit. The risk register has two components. The seven highest priority risks are documented seperately. The remaining risks are documented separately. The chair of the BOT and GM discussed the organisation’s risk management focus and the discussion aligned with risk register documents sighted. The risk register include mitigation strategies and a risk rating for each risk. The appointment of a GM with a clinical background and current annual practising certificate as a registered nurse (RN) is a part of the BOT risk management strategy.   There is a hazard register which identifies organisation hazards. The hazard register is dated as last reviewed in February 2012 and is overdue for review. This is an area requiring improvement. The health and safety meeting and quality meeting includes a component on new hazard identification/management. |
| **Finding:** |
| The hazard register has not been reviewed since February 2012. |
| **Corrective Action:** |
| Ensure the hazard register is reviewed and amended if required in a timely manner. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| A policy and procedure provides the frameworks for how incidents are to be reported, investigated and subsequently managed. Six staff interviewed are able to identify what type of events are to be reported (including falls, skin tears, bruising/injuries, medication errors, security concerns, damaged or missing property/equipment, near miss events and ‘anything out of the ordinary’), as well as how events are to be reported. The staff advise they are informed of relevant events at shift handovers. The number and type of events reported are sighted as being discussed in February 2014 minutes of the quality committee and health and safety meeting and is on the agenda for discussion at the staff meeting which is held during audit. Some modifications to the incident reporting form are in progress. A review of the 2013 and 2014 completed incident reports confirms that staff are reporting appropriate events including episodes of challenging behaviour, falls, lacerations, medications not taken and near miss events. Sufficiently detailed corrective action plans are not evident for all sampled events and this is raised as an area for improvement in 1.2.3.8. Evidencing that open disclosure has occurred following applicable events is not always documented and this is raised as an area for improvement in 1.1.9.1.  The GM is aware of the organisation’s responsibilities in relation to essential notification and is able to detail the events which are to be reported and to whom. The GM advises the DHB and Ministry of Health were advised of the change in manager in 2013. The police were also informed of the event in 2013 when a deceased person was left by members of the public in the Hospital Grounds.   The ARRC contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| A number of policies and procedures are available which provide the framework for recruitment and human resource practices. Eight staff files reviewed during audit evidence that prospective staff are required to complete an application for employment. Interviews occur and references checks and police checks are undertaken and documented. Copies of signed employment contracts, including a code of conduct are in sampled files. Whilst there is a process for monitoring annual practising certificates a staff member is sighted working without an annual practising certificate. A number of staff are overdue performance appraisals. These are areas requiring improvement.  The six staff interviewed confirm they are provided with a comprehensive orientation programme which includes an orientation to the facility, routines, keypersonnel, individual patient care needs, policies and procedures, emergency procedures and equipment. The staff advise the orientation is sufficient to prepare them for their roles and responsibilities. Staff are now required to complete the orientation programme within three weeks of employment and records sighted seven of eight staff files reviewed at audit. The remaining staff member has been employed less than three weeks and confirms the orientation is currently occurring.  An education calendar has been developed and regular in-services are provided for staff. The six staff interviewed confirm they can access education externally as well as within Pohlen Hospital. The topics of upcoming education sessions are advertised for staff. Records of attendance are maintained and sighted. The education programme records were sighted for training on the Code and advocacy (February and March 2013), respect and values (March 2013), managing challenging behaviour (February 2013), continence (July 2013), advance directives and enduring power of attorney (September 2013), and infection prevention and control (February and November 2013). The training records sighted also includes (but is not limited to) neonatal resuscitation, maternity service specific education, first aid training, intravenous therapy and pharmacology/medication management education.  ARRC contract requirements are met except D17 1.b I and ii and D17.7f. |

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

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

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| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| Annual practising certificates (APC’s) are sighted for 15 medical practitioners, two radiation technicians, three physiotherapists, three podiatrists, one occupational therapist, one pharmacist and a number of registered and enrolled nurses. One staff member is sighted to not have a current annual practising certificate. A copy of the staff member’s APC (at employment) is not present in the staff member’s file. The staff member advises this was provided to the prior manager at the time. The staff members details are not on the register of APC’s which is overseen by an administrator. The staff members APC is identified as having expired on 31 December 2013, however the staff member has continued to work. This is an area requiring improvement.  Three of six staff who have been employed for more than 12 months and whose records reviewed are overdue for their annual performance appraisals. The general manager confirms many of the staff appraisals are overdue and is a work in progress to ‘catch up’. On the day of the unannounced audit the GM had three staff appraisals scheduled to be undertaken that day. All of these occurred. |
| **Finding:** |
| 1. One staff member whose annual practising certificate expired on 31 December 2013 is currently working without registration.2. Three of six staff who have been employed for more than 12 months and whose records reviewed are overdue for their annual performance appraisals. The general manager confirms this is a work in progress. |
| **Corrective Action:** |
| A process is implemented to ensure all registered health professionals that are employed, contracted or hold an access agreement has a current annual practising certificate. Ensure performance appraisals are undertaken annually as required by the organisation and ARRC contract. |
| **Timeframe (days):**90*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| There is a policy which details how staffing is to be planned and implemented to ensure safe staffing levels and skill mix. A review of the current roster identifies: - there is at least one staff member on duty at all times who holds a current first aid certification or resuscitation certificate. - staff working in the maternity unit have completed neonatal resuscitation training. The RN’s are also provided with training on obstetric events. -there is at least one registered nurse rostered on duty every shift seven days a week. - there is one hospital aid rostered on duty or on call in the maternity unit - there are designated hours each day for cleaning, kitchen/food services and laundry services - where a staff member is unable to complete their roster duty a replacement is sourced - there are currently three hospital aids rostered to work a full morning shift and one hospital aid working 7am until 1.30 pm in the main hospital areas. - there is currently one hospital aid rostered to work a full afternoon shift and one hospital aid working from 3pm until 9-30pm and another works from 5pm until 9.00 pm in the main hospital areas. - there is a minimum of two staff on duty overnight in the main hospital area - a general practitioner is on call 24 hours a day, 7 days a week. This is shared between eight doctors. The RN advises a nurse practitioner undertakes many of the routine reviews of patients receiving services under the aged related care contract.  The GM and CQM advise the lead maternity carer LMC remains responsible for oversight of care provided to patients in the maternity service and this includes being on call.  The ARRC contract requirements are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| Each stage of service delivery is undertaken by suitably skilled staff. The registered nurses provide the nursing assessments for all new admissions, develop the care plan, evaluate and review the care (with consultation with the caregiver, referral information, patient and family/whanau) if available. The general practitioner (GP) or the nurse practitioner conduct the medical assessments and review the patient`s condition. The caregivers provide a majority of the personal care for the patients. There is an appropriate education programme for staff that covers the essential components of the organisation and service delivery. The nurse practitioner (NP) interviewed reports that staff have a good skills and knowledge and do not contact the GPs unnecessarily. The NP did not mind being called for any queries or advice. The annual practising certificates were sighted and all but one was validated for the health professionals employed or contracted to this service. Refer criterion 1.2.7.2.  The five of five patients` records reviewed (two maternity, one hospital medical, one (ARC) hospital and one (ARC) rest home) have evidence of routine initial assessments, initial care plans and goals on admission. Also taken into account are the physical, psycho-social, spiritual and cultural aspects of each patient.  For the age related residential care services a full interRAI assessment is performed by the two registered nurses who are fully trained to undertake this assessment. In addition recognised assessment tools for each admission are utilised including nutritional, continence, pain, skin, pressure risk and falls risk. More specific assessment tools are used for any patients presenting with dementia and/or challenging behaviours. The assessment tools are used to identify the patient`s identified problems and needs to develop the long term care plan. The long term care plan is developed within three weeks of admission. The long term care plan records the support needs, goals, interventions and evaluations which are individualised to each patient. The clinical quality manager explained the schedule sighted which is maintained electronically for all multidisciplinary reviews and care evaluations conducted six monthly or more often if required. Five patients including two patients in the maternity unit interviewed report high satisfaction with the care and services provided for all of the five services provided. There is no patients that are receiving the hospital care (surgical) which is a service also provided. Staff interviewed acknowledge the team work and that continuity of care is encouraged at every opportunity. The two lead maternity carers and one hospital maternity aide interviewed stated they worked collaboratively together as a team to cover this service effectively. The one family member interviewed spoke very highly of the care his partner received at this maternity unit during the three day stay.  The ARRC and maternity services requirements are met.  Tracer Methodology: Hospital medical (GP) primary care contract/Rest home ARC XXXXXX *This information has been deleted as it is specific to the health care of a resident*  Tracer Methodology: Medical/Day Stay 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*  Tracer Methodology Maternity: XXXXXX *This information has been deleted as it is specific to the health care of a resident* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| The policies and procedures for managing all services provided are available to guide staff. The policy manual is stored in the nurses` office in the rest home and hospital and there is a copy in the maternity unit for staff to access. The policies and procedures reviewed are clear and practical and provide guidance for the provision of patients` day to day health care. The five randomly selected records sighted are accurate and up to date to reflect the needs of the patients on the care plans. There are appropriate assessment forms in both the maternity service and in the hospital. All patients admitted under the ARC have a full comprehensive interRAI assessment performed by the registered nurses trained to complete these assessments. There are two registered nurses who have completed the appropriate training. All registered nurses are to be fully trained this year and this is now a requirement in the aged care sector. A copy of the interRAI assessment is printed out and placed in the front of each resident`s individual record for staff to access. These assessments are used as the basis of care planning in conjunction with the NASC support link Waikato assessments performed prior to admission to this service. Other recognised assessment tools are also utilised, such as the Norton scale, pain assessments, challenging behaviour assessments and others.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| Pohlen Hospital offers activities for patients every day of the week except Sundays. A qualified diversional therapist (DT) provides and manages this area of service delivery with the support of an activities co-ordinator who assists in the implementation of the programme and can cover in the absence of the DT if required. The diversional therapist is a member of the New Zealand Diversional Therapists Association (NZDTA) and is well informed of any changes. Both attend networking with other like services in the region when possible.  The activities programme is developed monthly by the DT but displayed on a weekly basis around the facility. All patients are individually assessed by the DT as part of the admission process to identify their likes/dislikes, previous social and family/work histories and any cultural needs are identified. From the information gained with support for the patient and/or family/whanau an individual activities plan is developed and implemented. The patients receiving long term care each have their own activities plan which were sighted. These plans are reviewed six monthly or in association with the multidisciplinary team meeting. Attendance records are maintained of the activities each patient engages in and their enjoyment of the programme. Observations and discussions with the patients and their families is encouraged to meet the needs of the individual patients.  Patients are offered a range of group and one-on-one activities, including exercise, bowls, movies, hair care, quizzes, musical entertainment, outings, baking, walks and craft activities. Bible readings are held weekly and a church service monthly. There has been an added addition to the main lounge and the enlargement of the room has made a big difference for patients. A piano is available, a library, a large screen television and new comfortable chairs are provided. A sunroom with a large pull out shaded area is off the lounge with even floor surfaces, sun umbrellas and appropriate seating for inside the sunroom and/or outside. There is a cat and budgies that belong to the facility. Entertainers and other volunteers visit most weeks. National event days are celebrated. Patients` families are invited to attend and participate anytime in the activities programme.  A dedicated van with a current registration and warrant of fitness is used to help residents engage with the community, such as weekly outings for drives, café visits or visits to the Returned Services Association (RSA) in Matamata township. The Chief executive officer ensures al van drivers have a current driving licence. Entertainers are welcome to come into the facility by arrangement and perform for the patients. School children and musical acts are encouraged. The service is assessed formally through the service satisfaction surveys.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| Nursing reviews and assessments, medical/LMC and specialist consultations on site and admission to hospital for specialist treatment is clearly documented in the (five of five) patients` records reviewed. Documentation reflects that evaluations of care plans for long term patients is conducted at least six monthly (confirmed in all records reviewed) or more often if necessary. A schedule was sighted which was maintained electronically and explained by the newly appointed clinical quality manager to ensure that the reviews occur in a timely manner. Evaluations in the five of five records reviewed are documented and are patient focused and indicate the degree of achievement or response to support/interventions and progress towards meeting the desired outcomes. The six monthly multidisciplinary meetings (MDT) is sighted in the (two of two) long term care patients records reviewed. The one family member interviewed of a long term patient confirms an invitation is extended for the family to have input into this meeting six monthly.  The family of one of two long term care patients interviewed report they can consult with staff at any time if they have concerns and staff inform them of any changes in the patient`s condition. Any family contact is documented in the progress records and on the family contact record sheet in each patient`s individual records. The respective care plans are clearly updated.  The husband of the maternity patient interviewed was grateful for the reassurance and updates provided by the LMC and staff registered midwife in the emergency situation his wife was experiencing whilst in the maternity unit. The hospital maternity aide provided support to the baby and the husband during this time and this was also acknowledged. Progress records were well documented and signed and dated by the person making the entry into the records. Designations are included in the five records reviewed.  The ARRC agreement requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| The service has a medicine management policy which has been reviewed in August 2013. As well as the services own policies and procedures being documented and reviewed the service uses the Waikato DHB Medicine Management Policy Guidelines which comply with legal, organisational and cultural requirements. This folder is held in the Nurses` Station. Guidelines are available for prescribing and dispensing medications, ordering medications from the pharmacy, medication storage and disposal, medication administration, administration of controlled drugs, administration of intravenous medications, medication on discharge, monitoring and errors, medical standing orders. There is clear evidence that policies and procedures have been implemented for the services provided. One of the patients in the medical day stay received an iron infusion and the guideline for this was sighted at audit and followed by the registered nurse interviewed who was responsible for the patient during this procedure.  Ten of ten patient medication records are available for review (three from the maternity unit, two medical day stay and five long term care patients` records). Medicines for patients received from the contracted pharmacy on site are packed in the robotic system and delivered in rolls for each individual patient. All medication received from the pharmacy is checked by two senior staff on arrival. A safe system for medication management is observed during the audit (lunchtime) medicine round.  The maternity unit has a small amount of medications due to the nature of this service being a primary birthing unit. The maternity service policies and procedures were reviewed August 2013. Mild analgesic medications, ecbolics such as syntocinon and sytometrine (stored in the fridge) and emergency medications are stored appropriately in a locked room. No controlled drugs are stored in the maternity unit. When required these can be accessed by the lead maternity carer from the hospital. The registered nurse in charge and the LMC would check the medication as per the documented protocol sighted. The controlled drug book was checked and verified balances and checks are performed weekly. Storage is appropriate and the medication room is locked at all times. The medication trolley is also lockable and stored in the medication room when not in use.  The temperature of the medication fridges are checked daily inclusive of the fridge in the maternity unit for storing the ecbolic medication. Any discontinued medication is ruled through and signed and dated appropriately by the GPs and/or the one nurse practitioner from the medical practice who visits patients on a regular basis to perform both medical and medication reviews. The nurse practitioner was available for interview by phone. There is a self-medication policy but there are no patients` currently self- medicating medications. Staff and GP specimen lists are available and sighted. Bright stickers are utilised for allergy and sensitivities on the clinical records and on the medication records.   There are two areas of required improvement identified in relation to medication management 1.3.12.1 and 1.3.12.3. These include medication standing orders are overdue for review by the general practitioners` and the three monthly medication reviews are not documented on the medication records sighted. In addition medication competency assessments have not been undertaken for all applicable staff annually as documented in the medication policy 1.3.12.3. Both are requirements for the ARRC which has not been effectively met. |

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

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

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| **Attainment and Risk:**PA Low |
| **Evidence:** |
| A medication management system is implemented to manage safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols and guidelines. It was evidenced that the standing orders are overdue for review as these are normally done on an annual basis. The ten of ten medication records sighted did not verify that the three monthly medication reviews are documented as being completed on the individual medication records. |
| **Finding:** |
| Medication standing orders are overdue for review. They are dated as last reviewed in 2012. The three monthly medication reviews are not documented on the medication records to evidence this has occurred. |
| **Corrective Action:** |
| Ensure medication standing orders are reviewed at least annually. Ensure documentation evidencing three monthly medication reviews is present on each resident’s individual medication record. |
| **Timeframe (days):**180*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:**PA Moderate |
| **Evidence:** |
| Service providers responsible for medicine management are competent to perform the function for each stage they manage. The education records reviewed do not evidence that all staff administering medications have completed a medication competency in the last twelve months as required. |
| **Finding:** |
| Medication competency assessments have not been undertaken for all applicable staff in the past twelve months. |
| **Corrective Action:** |
| Ensure staff administering medications are assessed for competency on at least an annual basis and that this is recorded. |
| **Timeframe (days):**90*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| The senior cook interviewed has worked in the kitchen for nine years and seven years in the current position. The cook discussed the summer/winter menus and rotation system utilised and input from a registered dietitian was evidenced. The kitchen policies and procedures have been reviewed in 2013. A hazard list was sighted in the kitchen. Kitchen hygiene and cleaning schedules are displayed. The kitchen hand interviewed has worked in the kitchen for six months and is fully aware of these responsibilities to be completed daily and additional cleaning as required. Contractors complete any high cleaning by arrangement. The local council collects any rubbish on a weekly basis and waste is recycled appropriately. All staff have completed the infection control hand hygiene competencies. A food service audit was performed in January 2013. The cook interviewed stated that special days are celebrated such as birthdays, theme days for activities and other special occasions during the year. The service also caters for meals on wheels in the community (thirty two meals prepared and volunteers deliver to people in the community) Monday to Friday. The cook also caters for volunteer`s functions held regularly as well as meeting the needs of the services audited.   The cook is responsible for the temperature monitoring in the kitchen for the main fridges and the kitchen freezer. The cook is also responsible for the ordering of all food supplies for this service. All stock is checked when delivered and the temperatures of all frozen goods are monitored. Food is stored appropriately. Food is rotated and labelled as needed with dates and signatures. The service contracts with large companies for fresh fruit and vegetables, milk, eggs, baking products, bread and dry stock supplies. Meat is purchased locally. The pantry is cleaned weekly. There is a freezer room and a dry stock room separate from the kitchen which are well maintained clean and tidy.  The registered nurses when admitting a resident complete a nutritional assessment and any dislikes, likes, preferred foods, required foods or supplements are ascertained. A copy of this assessment is given to the cook. Any special diets, serving sizes or special needs such as mouli foods can be arranged. A whiteboard in the kitchen with all details is evident to remind kitchen staff. The menu is displayed in the dining room lounge area daily. A beverage list is available for all services and the hospital and women in maternity can have smoothies. Snacks and additional meals are available for the maternity unit and menus are provided daily with choices of foods for the twenty four hour period. The two patients in the maternity service interviewed stated that they enjoyed the meals very much. Other patients interviewed also commented that the food was enjoyable and met their individual needs.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| There is a current building warrant of fitness (BWOF) displayed with an expiry date of 1 September 2014. Systems to maintain the BWOF regular checks are being maintained.   At the last audit bottles of medical gases were not sufficiently secured/stored and this was an area requiring improvement (1.4.2.3). This has been addressed and all sighted bottles of medical gases are safely secured and now meets the requirements of the standard.  The ARRC contract requirements are met for the criteria audited. |

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

All buildings, plant, and equipment comply with legislation.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:**FA |
| **Evidence:** |
| The restraint/enabler minimisation and safe practice policy details the organisation’s processes for the assessment, approval and monitoring processes for patients where restraint is being considered or required. The risk assessment process and staff training requirements are also noted. The policy includes the definitions of restraints and enablers and the definitions align with the requirements of the standards. Four staff interviewed (three hospital aids and the activity programme facilitator on the day of audit) are able to identify that enablers are required to be voluntary and the least restrictive option.  Staff are provided with training on managing challenging behaviour as a component of the orientation and ongoing education programme. The training records sighted includes managing behaviour (February 2013 – attended by 17 staff), restraint minimisation and use of enablers (April 2013 – attended by five staff and November 2013 – attended by 4 staff).  At audit there are seven residents who have bedrails in use as an enabler and three residents with restraints in use (either bed rails or a fixed tray). The use of restraint is minimised via use of high low beds and sensor mats. The use of restraints, enablers and restraint minimisation strategies are monitored monthly and the use of restraint alternatives noted to be working well as identified in the restraint related documents sighted. |

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

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

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

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

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

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

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| **Attainment and Risk:**FA |
| **Evidence:** |
| There is clear definition of surveillance in the surveillance policy sighted and how this can be applied to all services inclusive of the maternity service, The type of surveillance is set up by the clinical quality manager, an experienced enrolled nurse and a health care assistant/caregiver who make up the infection control team for this organisation. The service infection control manual is readily available for staff to access as well as the guidelines in the Bug Control Manual which is a good resource and reference material for infection control and is continually updated. The manual was updated last in 2013. Bug Control is also an infection control advisory service. Infection control meetings are held monthly and minutes sighted for the 29 March 2013 and 3 July 2013 were sighted. The infection control surveillance is appropriate to the size and complexity of all services provided inclusive of the primary maternity service. The infection control team is required to take responsibility for surveillance activities as shown in the policy. Monitoring clearly describes actions to be taken to ensure patients` safety at all times.  There is a monthly surveillance report. The service monitors in all services provided inclusive of maternity services the incidence of urinary tract infections (UTIs), eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections or hospital acquired infections. Information is obtained from the infection record form in each patient`s individual records sighted. A monthly electronic spread sheet is maintained, graphed results are printed out and a record is retained in the infection control record folder. Any issues are fed back to staff at the staff meetings. Any education needs are discussed and sessions are arranged to meet the needs of the staff and/or patients/families if relevant. There have been no outbreaks reported since the last audit. Monitoring of infections and evaluations of relevant practices are acknowledged and audits are performed regularly to ensure compliance especially in relation to hand washing competencies and wound care management. |

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

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

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

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

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

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