# Presbyterian Support Central - Chalmers

## Current Status: 14 April 2014

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

## General overview

Chalmers is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 80 residents. There is a supportive management team in place.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There are adequate staff numbers on duty.

his audit identified improvements required around wound management, aspects of medicine documentation and documentation of interventions.

## Audit Summary as at 14 April 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 14 April 2014

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

### Organisational Management as at 14 April 2014

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

### Continuum of Service Delivery as at 14 April 2014

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

### Safe and Appropriate Environment as at 14 April 2014

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

### Restraint Minimisation and Safe Practice as at 14 April 2014

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

### Infection Prevention and Control as at 14 April 2014

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

## Audit Results as at 14 April 2014

### Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the foyer of the facility. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents', cultural and spiritual preferences. Residents and family interviewed spoke very positively about care provided at Chalmers. Complaints processes are implemented and complaints and concerns are managed within the required timeframes.

### Organisational Management

The service is managed by a registered nurse manager with management experience who has been in the role four months. She has been completing orientation including company leadership and Eden training. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that has been implemented at Chalmers. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. Quality committee and senior management meetings includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings and three monthly resident meetings

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

### Continuum of Service Delivery

The service has a comprehensive admission policy. Comprehensive pre-admission information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision. Service delivery plans demonstrate service integration. Care plans are reviewed six monthly. Resident files include notes by the GP and allied health professionals. Improvements are required around wound management documentation, clinical observation post un-witnessed falls, pressure area interventions, documentation of enabler risks in care plans. During the tour of facility it was noted that all staff treated residents with respect and dignity and residents and families were able to confirm this observation. There is a recreation coordinator that is responsible for activities, identifying different needs that are appropriate to their age culture and differing health status. The activity plans are developed on admission with the resident and family/whanau where appropriate and noted on their care. There is a robust medication system and practice observed meets medication administration requirements. Improvements are required around "as required" (PRN) prescribing. The food and laundry services are managed safely and in line with required guidelines. Resident’s likes and dislikes and dietary requirements are identified, met and reviewed.

### Safe and Appropriate Environment

Chalmers PSC has waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. All electrical equipment is checked annually and clinical equipment calibrated. In the facility residents are able to bring their own possessions to promote a familiar environment. Consideration is given to residents needs when purchasing new furniture/equipment. The physical environment is appropriate and safe. There is adequate space and external areas are well kept. Laundry is completed on site and cleaning and laundry are monitored frequently. There is a staff member on duty at all times with a current first aid certificate and there are enough civil defence supplies, water and food to allow the service to be self-sufficient for at least three days in the event of a civil emergency.

### Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is needed. There are currently 18 residents using bedrails as enablers. Staff receive training around maintaining a restraint free environment. The enabler co-ordinator maintains enabler documentation and an online register.

### Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (the quality co-ordinator) takes overall responsibility for ensuring that the surveillance programme is well implemented with review of trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that trends are identified with corrective actions and outcomes communicated to staff.

All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Presbyterian Support Central |
| **Certificate name:** | Presbyterian Support Central - Chalmers |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Chalmers Elderly care | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 14 April 2014 | **End date:** | 15 April 2014 |

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

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

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 6 |
| **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 | 24 | Total audit hours off site | 16 | Total audit hours | 40 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 17 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 85 | Number of relatives interviewed | 10 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Friday, 16 May 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Chalmers is part of the Presbyterian Support Central organisation. The facility provides rest home and hospital level care for up to 80 residents. There were 41 rest home and 37 hospital beds occupied at the time of audit. There is a supportive management team in place.  A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There are adequate staff numbers on duty.  This audit identified improvements required around wound management, aspects of medicine documentation and documentation of interventions. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the foyer of the facility. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents', cultural and spiritual preferences. Residents and family interviewed spoke very positively about care provided at Chalmers. Complaints processes are implemented and complaints and concerns are managed within the required timeframes. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| The service is managed by a registered nurse manager with management experience who has been in the role four months. She has been completing orientation including company leadership and Eden training. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that has been implemented at Chalmers. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. Quality committee and senior management meetings includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings and three monthly resident meetings Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.  There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a comprehensive admission policy. Comprehensive pre-admission information is made available prior to entry and in the welcome pack given to the resident and family/whanau. Residents/relatives confirmed the admission process and that the agreement was discussed with them. Registered nurses are responsible for each stage of service provision. Service delivery plans demonstrate service integration. Care plans are reviewed six monthly. Resident files include notes by the GP and allied health professionals. Improvements are required around wound management documentation, clinical observation post un-witnessed falls, pressure area interventions, documentation of enabler risks in care plans. During the tour of facility it was noted that all staff treated residents with respect and dignity and residents and families were able to confirm this observation. There is a recreation coordinator that is responsible for activities, identifying different needs that are appropriate to their age culture and differing health status. The activity plans are developed on admission with the resident and family/whanau where appropriate and noted on their care. There is a robust medication system and practice observed meets medication administration requirements. Improvements are required around "as required" (PRN) prescribing. The food and laundry services are managed safely and in line with required guidelines. Resident’s likes and dislikes and dietary requirements are identified, met and reviewed. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| Chalmers PSC has waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. All electrical equipment is checked annually and clinical equipment calibrated. In the facility residents are able to bring their own possessions to promote a familiar environment. Consideration is given to residents needs when purchasing new furniture/equipment. The physical environment is appropriate and safe. There is adequate space and external areas are well kept. Laundry is completed on site and cleaning and laundry are monitored frequently. There is a staff member on duty at all times with a current first aid certificate and there are enough civil defence supplies, water and food to allow the service to be self-sufficient for at least three days in the event of a civil emergency. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint is needed. There are currently 18 residents using bedrails as enablers. Staff receive training around maintaining a restraint free environment. The enabler co-ordinator maintains enabler documentation and an online register. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (the quality co-ordinator) takes overall responsibility for ensuring that the surveillance programme is well implemented with review of trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that trends are identified with corrective actions and outcomes communicated to staff.  All surveillance activities are the responsibility of the infection control coordinator with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 43 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 0 | 2 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | (i)One pressure area reported on an accident and incident form has not been updated in the care plan or documented on a short term care plan; (ii) One long term resident’s care plan (rest home) does not have falls management strategies documented following reports of falls on accident and incident forms. The care plan evaluation for that resident states “no falls”. (iii) The progress notes and accident and incident form for a rest home resident documented an un-witnessed fall. Neurological observations were not completed as per the policy for un-witnessed falls (iv) Risks associated with enabler use (bedrails) is not documented on the assessment forms or the care plans in three of three resident files sampled with enabler use. (v) Sixteen of sixteen short term wound care plans did not have initial assessments completed that described the wound. Two of sixteen short term care plans for wounds had not been transferred onto the chronic wound care plan after three weeks. Sixteen of sixteen short term care plans for wounds do not have documented evaluation of the wound healing progress at each dressing change. | (i)Ensure pressure area interventions are documented in the care plan. (ii) Ensure neurological observations are completed as per policy. (iii) Ensure risks associated with enabler use is documented in the care plan. (iv) Ensure wound management documentation is completed as per policy | 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 Moderate |  |  |  |
| 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 Moderate | 15 of 18 medication charts reviewed did not have indications for use for PRN medications documented. | Ensure all PRN medications charted have indications for use charted that are specific for that resident | 60 |

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

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

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has available information on the Code of Health and Disability Services Consumers’ Rights. The Code was evident around the service. There is a resident rights policy in place. Code of Rights training is included in orientation and included into the company study days.  Discussion with eight health care assistants (four morning and four afternoon shift) confirms they are all were aware of the code of rights and could describe the key principles. |

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

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

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

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

Consumers are informed of their rights.

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident’s rights information is available. The code of rights and advocacy pamphlets are located in the foyer at the reception area.  D6.2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet, advocacy and H&D Commission information. The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents, such as audio tape. The interpreter service information is also available in the resident orientation pack. Staff will read information to residents and explain it (e.g. informed consent and code of rights). Information is also given to next of kin or enduring power of attorney (EPOA) to read to or with the resident and discuss in private.  On entry to the service the manager or care manager discusses the information pack with the resident and the family/whanau. This includes the code of rights, complaints and advocacy.  Seven residents (three hospital and four rest home) and 10 relatives (six hospital and four rest home) stated they were well informed about the code of rights and the service provides an open-door policy for concerns/complaints. Information on complaints and compliments includes information on advocacy. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records.  There is a comprehensive resident records policy that includes; a) integrated resident records, b) information requirements, and c) integrity of computerised records. Discussions with seven residents and 10 family members identified that personal belongings are not used as communal property. The staff are observed to be respectful of entering a resident’s room and gained permission before doing so.  D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. D4.1a: The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. The support plan includes a 'spirituality, faith and culture' section and this is completed in nine of nine resident files (four rest home and five hospital) sampled. There is a sexuality and intimacy policy. The service includes within its care planning assessment, directions for emotional wellbeing and this includes sexuality and intimacy. Discussions with residents and family members confirmed that residents are able to engage in activities and access community resources as they choose. Discussion with eight health care assistants could describe examples of giving residents choice including, what time they would like to get up, choices on food, and what they would like to wear.  The service implements the Eden Philosophy and staff could describe a more resident-focused care instead of task orientated. There is an elder abuse and neglect policy and abuse or neglect reporting process. Elder abuse and neglect training is compulsory to attend at least every two years as part of the health care assistant (HCA) and registered nurse (RN) study days. Discussions with management (the quality coordinator, the care managers and the facility manager) and staff (eight HCAs, two RNs and the activity person) identified that there were no incidents of abuse or neglect and that there is a culture of reporting.  Ten family members and seven residents interviewed are very positive about the quality of care and support provided to residents. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| A3.2: There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The Presbyterian Support wide Maori Health plan has been reviewed and updated through the Maori Health plan Wellington Group. There is a site specific Maori heath plan.  Cultural and spiritual practice is supported. There are employee guidelines to guide staff in the delivery of culturally acceptable care for Maori residents. The service has access to a cultural advisor with links to local Iwi. The service identifies the need for staff to be trained in delivering appropriately cultural services. Cultural/treaty training has been provided as part of the Health Care Assistant and RN study days for all staff. There are currently no Maori residents.  Discussions with staff identify that have responded appropriately to the cultural needs of residents and their whanau.  Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety when caring for Maori residents. |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan. D3.1g: The service provides a culturally appropriate service by identifying individual needs. The one xxxxx resident has specific cultural needs identified in the care plan and the eight health care assistants and cook (interviewed) are able to describe the resident’s individual cultural needs.  D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. The service provide a chaplaincy service and on-site church services.  Discussions with residents and family members confirmed they were satisfied that staff considered their individual values and belief. This was also reflected in support plans. |

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

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

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

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

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

ARHSS D16.5e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a code of ethics policy. Job descriptions include responsibilities of the position and ethics, advocacy & legal issues. Registered Nurse and Enrolled nurse job descriptions include upholding legal and ethical standards and accountability and responsibility. The orientation booklet provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts. Understanding the code of conduct and information technology (IT) usage policy is signed as part of orientation. Completed orientation packages were sighted in nine of ten staff files sampled. The facility manager orientation is still in progress.  Two RNs, two care managers and eight HCAs interviewed have a good understanding of professional boundaries. Residents and family members report that staff are always professional. |

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

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

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

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

Consumers receive services of an appropriate standard.

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. Policies and procedures cross-reference other policies and appropriate standards. RN’s are encouraged and supported to continue education. Health care assistants are supported to complete Career Force or unit standards. A2.2 Services are provided at Chalmers that adhere to the health & disability services standards. There is an implemented quality improvement programme that includes performance monitoring. D1.3 All approved service standards are adhered to. D17.7c.There are implemented competencies for HCAs, enrolled nurse and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. The service has implemented a number of improvements since the previous audit. These include:  a) Recreation programme now offered 7 days a week.  b) Nutritionally assessed full 5 week vegetarian menu now available with recipes. New food IT system that allows automatic food ordering and recipes to be printed with quantities linked to actual number of meals required. This minimises wastage from cooking too much and also ensures that there is enough food. On line recipes also allow relief cooks to have access to recipes for dishes they are unsure of. “Special week” menus and recipes are also available to substitute for the standard weeks, e.g. queen’s anniversary week menu. There are a number of ethnic recipes e.g. Indian, Chinese available and the next project is to expand the repertoire of ethnic recipes and prepare fully nutritionally assessed menus. Cooks teleconferences started on a bi-monthly basis to review any issues around the menu, deliveries and to share ideas for resident involvement.  c) Administrators manual developed and updated as required with all links to appropriate sites to ensure compliance with statutory changes are communicated and available when required. d) First version of Managers manual completed and available on line. e) Residents involved in recruitment of new staff. f) Relatives and friends information booklet printed. Residents and families involved in business planning process. g) Systems and information regarding EPOA updated.  h) Environmental changes increase resident independence and autonomy e.g. kitchen added, smaller dining room. Kitchenettes set up with tea, coffee, toaster, fruit bowl etc. Residents families are encouraged to have family meals together (cooking facilities available). i) Enabler and Infection Control Coordinator Days. j) Preferred product list of medical consumables. k) Establishment of new treatment room. l) Computer nook with Skype capabilities for residents. m) Development planned for education suite.  Resident meetings are held regularly. Family meetings are held with guest speakers invited to attend.  Staff attend compulsory education and study days. Staff have access to the Enliven library which includes gerontology journals and updated best practice guidelines. Staff are required to read information/reviewed policies and procedures in the reading folder and sign to acknowledge they had read them. Shift handovers ensures there is continuity of service delivery. Eight caregivers interviewed are knowledgeable in the use of care plans and short term care plans which guide them in the safe and timely delivery of services for the residents. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Discussions with seven residents and 10 family members all stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur three monthly and the facility manager and has an open-door policy. Review of 15 incident forms from March 2014 identified that relatives are informed in all cases where appropriate. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: 10 relatives (six hospital and four rest home) stated that they are always informed when their family members health status changes. D 13.3: Nine resident admission agreements sighted are signed. The admission agreement contains a schedule of fees and charges where applicable.  Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry. The admission agreement has recently been reviewed at an organisational level to make it more user friendly for residents and families. D11.3: The information pack is available in large print and advised that this can be read to residents. There has been a relatives and friends information booklet developed.  The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and their families are provided with all relevant information on admission. Discussions are held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained includes the following: collection and storage of information, delivering of care including minor procedures as wound care, X-rays and podiatrist, photograph for display and identification purposes, transport and outings, family involvement in assessment, care planning and evaluation of care and students delivering care. The consent forms also state the resident may withhold or decline to consent for any specific procedure. The two care managers and two RNs and eight HCAs interviewed were knowledgeable in the informed consent process. All resident files have a resuscitation form. The GP signs to deem the resident competent or not competent. Where the resident is deemed incompetent the GP discusses medical indications for or not for resuscitation with the EPOA or family. The GP and RN sign the resuscitation form. Nine resident files sampled (five hospital and for rest home had appropriately signed resuscitation forms.  D13.1 there were nine admission agreements sighted and nine had been signed prior or on the day of admission. D3.1.d Discussion with 10 family (six hospital and four rest home) identified that the service actively involves them in decisions that affect their relative’s lives. |

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

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

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

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

The service is able to demonstrate that written consent is obtained where required.

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

##### **Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Client right to access advocacy and services is identified for residents and brochures are readily available. The information identifies who the resident can contact to access advocacy services. Information provided to residents and family/whanau at the time of entry to the service includes advocacy information. Staff (interviewed) are aware of the resident’s right for advocacy and how to access and provide advocate information to residents if needed. The welcome booklet includes a section around ‘client advocates’. D4.1d; Discussion with 10 family members identified that the service provides opportunities for the family/EPOA to be involved in decisions. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Family members and residents confirm that visiting can occur at any reasonable time. This is stated in the resident information pack.  D3.1h: Discussion with seven residents shows that they are encouraged to be involved with the service and in their care. Residents can access community services as they require. Discussions with staff, residents and relatives identified that the service encourages residents to belong to community groups. There is interaction with a local preschool. There are community volunteers, and community groups come and entertain. D3.1.e: Discussion with RNs, HCAs the recreation officer and the care managers indicates that residents are supported and encouraged to remain involved in the community and external groups visit. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. Residents and family members confirmed that management are very approachable should they have any concerns. Complaints information is included in the resident and relative information pack. The complaints form is readily available and attached to Enliven complaints brochure. The brochures are displayed in the foyer.  There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the register with evidence of follow up and resolution. There has been one verbal relative complaint in 2014. The complaint has been appropriately investigated and resolved to the satisfaction of the complainant. Advocacy was offered and the privacy officer (facility manager) has completed a six week follow up. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Chalmers is part of the Presbyterian Support Central organisation. The service provides rest home and hospital level care for up to 80 residents (41 rest home beds, 27 hospital beds and 10 hospital/rest home beds). On the day of the audit there were 78 residents. There were 41 rest home residents (includes one respite care and one under 65 years of age) and 33 hospital level of care residents (includes three under 65 years of age).   Chalmers has a documented mission statement, vision, values, goals corporate commitment and older person’s services goals. There is a company operational plan and site risk management plan evidences regular reviews for 2013. There is an Enliven (Chalmers) business plan for June 2014 – June 2015 that is in progress with an action plan to meet the identified goals. Residents and staff are involved in the business planning process.  The PSC building committee maintain close liaison and consult with the service regarding any plans for refurbishment or building development.   The facility manager was appointed to the role four months ago. She is a registered nurse with previous clinical and management experience and has completed a diploma in business management in 2013. The facility manager has completed at least eight of training within the last year relating to the management role and includes PSC leadership training, Eden training, spark of life training and assessor training. The orientation period is almost complete. The regional manager, who covers seven PSC facilities, also provides support.  The facility manager (RN) is supported by a regional manager (non-clinical), an educator, two care managers (rest home and hospital) and the PSC clinical director. The service has a robust structure that supports the continuity of management and quality of care and support (including staff management). The senior management team attend a two day peer support training day each year. There are three regional managers meetings a year. The management team (interviewed) feel well supported by the company.  Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care.  ARC D17.4b The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| In the absence of the facility manager an individual with relevant experience is delegated with the responsibility of fulfilling the manager role. The delegated person is the care manager with support from the regional manager.  D19.1a; A review of the documentation, policies and procedures and discussion with staff identified that the service has operational management strategies and a quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator on-site. The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to continually improve the service delivery to its residents. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS quarterly benchmarking programme that is implemented at Chalmers. The service has a quality coordinator. Quality meetings includes key staff from all areas of service. Quality reports provided to the committee by members include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry/ domestic/cleaning monthly report, e) IC monthly report, f) enabler monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) maintenance report ( meeting minutes sighed).  Other regular site meetings include; weekly senior team meetings, professional nurses meetings, care meetings, enabler co-ordinator meetings, recreational staff meetings, kitchen meetings and resident meetings. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness. .  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator. The internal audit company schedule has been combined to include QMP and QPS monitoring. The service completes the mandatory audits and chooses an additional audit monthly. Reports completed identify criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. When a shortfall is identified the area is re audited until a satisfactory result is obtained. A wound management audit completed in March 2014 with a 95% result is due for re-audit in two months. The quality co-ordinator (interviewed) is responsible for ensuring corrective actions have been implemented and signing off audit reports. Annual resident satisfaction surveys are completed as per company schedule. Results are communicated to the relevant committees and staff.   Policies and procedures cross-reference other policies and appropriate standards. There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule D5.4: The service has policies/ procedures to support service delivery.  The service has a health and safety management system and this includes the appointment of three health and safety representatives who have completed health and safety training. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.  There are comprehensive infection policies and procedures and a restraint/enabler policy and health & safety policy/procedures. There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has been kept (now on-line) and sessions evaluated.  Resident’s files no longer relevant to the service are removed and archived in a locked cupboard. Old policies are shredded. The service advised that records are maintained for 10 years. There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures are generated from head office. The quality co-ordinator is responsible for document control within the service ensuring staff are kept up to date with the changes.  a) Monthly accident/incident/near hit reports are completed by the care manager/facility manager. Monthly data is collected across the facility including staff incidents and accidents. These are compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents. There is an online database for recording accidents and incidents with medication errors reported separately. Incidents and accidents are also reported to PSC clinical director monthly.  b) The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.  c) There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database. QPS data analysis includes: wound infection rate, skin infection rate, UTI’s, respiratory tract infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the three month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken as scheduled during the year. d) Health and safety monthly reports are completed for each service and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified.  e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Chalmers is currently restraint free with enablers in use.   The service benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk. A hazard register is established for the site that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections. Civil defence procedures are in place and supported by staff training. There is a facility risk management plan 2013 to 2014 and a draft to be finalised for 2014-2015. The service documents risk or areas of concern and remedial action is identified as a result.  D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as sensor mats and individual review of residents who fall. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Fifteen accident/incident forms were sampled from March 2014. All show the form has been fully completed and reviewed by a registered nurse. All have on-going review and where appropriate actions to prevent recurrence completed by either the care manager or the facility manager. Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data that is then displayed for staff information. The monthly reports are discussed at all clinical meeting and staff meetings and include the QPS benchmarking indicator results and analysis of manual handling injuries, skin tears, pressure areas, resident falls, resident accidents, medication errors, and staff accidents. One pressure area reported on the accident/incident form did not have pressure area interventions documented on the short term care plan (link 1.3.6.1).  D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. All resident accident/incidents are reported on the correct form. There is documentation in the health status summary of all incidents. There is evidence of neurological observations completed for one fall with head injury. There is a requirement to complete neurological observations following un-witnessed falls (link 1.3.6.1.). The next of kin have been notified in 15 of 15 accident/incidents sampled  D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including registered nurses (RNs), enrolled nurse (EN), pharmacists, podiatrist, physiotherapist and GPs is kept. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (one facility manager, one care manager, three RN’s, four HCAs and one cook). Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. Annual appraisals have been completed for eight of ten staff files sampled. Two staff have not been employed with the service long enough for an appraisal.  A comprehensive generic orientation programme is in place that provides new staff with relevant organisational information for safe work practice. This was described by staff and records are sighted. Staff are allocated a full day to complete the generic orientation booklet. The new staff member is supported during their orientation to their work area. There is an implemented specific RN orientation book and RN competencies are completed. RNs and ENs attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements. Eight RNs have completed InterRAI training. First aid training is completed for all RNs, EN, activity staff and maintenance person.  HCAs attend study days as scheduled to meet mandatory education requirements. The service employ an RN educator/career force assessor to work with students and complete assessments. The educator also supports staff through their orientations and sign off when completed. The physiotherapist provide annual manual handling training. Caregivers and support staff are encouraged and supported to undertake external education. Career force training is supported. The organisations policy is that after three months of employment all caregivers and support staff must be enrolled in Career Force. Literacy and numeracy training is offered.  Senior cook is registered and undergoing Chefs qualification and other kitchen staff are undergoing level 2 food preparation course.   D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for caregivers. All individual records and attendance numbers are maintained on-line. Monthly reporting of training completed and staff attendance is reported to the regional manager and clinical director monthly. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.  The care managers (rest home and hospital) work 40 hours per week plus on call. Registered nurses cover each 24 hour period in the hospital area.  The HCA numbers per area are: Rest home – three HCAs on the full morning shift and two HCAs on short morning shift; Hospital area – five HCAs on the full morning shift and two on the short morning shift.  Afternoon shift for rest home are two HCAs on the full afternoon and one HCA on the short afternoon shift. Hospital staff are three HCA on the full afternoon shift and three HCA on the short afternoon shift. There are two HCA on night shift in the rest home and one HCA with the RN on night shift in the hospital. Casual staff are available to cover staff illness.  Staff interviewed including eight caregivers, the recreational team, and the care managers’ report adequate staff cover.  Seven residents and 10 family members report adequate staffing levels. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The resident files are appropriate to the service type.  Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure nurse’s station within the rest home and the hospital areas. Support plans and notes are legible and where necessary signed and dated with designation of the person making the entry. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry.  D7.1 Entries are legible, dates and signed by the relevant health care assistant, enrolled nurse or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and specialists involved in the care of the resident. |

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The needs assessment coordination service (NASC) ensures all residents are assessed prior to entry for rest home or hospital level of care. A placement authority form is sent to the receiving facility. The facility manager or care manager is responsible for the screening of residents to ensure entry has been approved. The potential resident and family receive a tour of the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission. The information pack includes all relevant aspects of service and associated information such as the Health and Disability Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation which includes resident and next of kin details. The facility manager (interviewed) is able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission. The RN on duty completes all the admission documentation and relevant notifications of entry to the service. Signed admission agreements are sighted. Seven residents (four rest home and three hospital) and ten relatives (four rest home and four rest home) interviewed state they received all relevant information prior or on admission. The GP is notified of the new admission.   D13.3 The nine admission agreements reviewed align with a) -k) of the ARC contract D14.1 exclusions from the service are included in the admission agreement. D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement  The admission policy and resident information handbook outline entry criteria, access, assessment and entry screening processes. There is an admission policy, resident admission procedure and a documented procedure for respite resident admissions. Seven residents (three from the hospital and four from the rest home) and ten family members (four from the rest home and six from the hospital) interviewed confirmed that they had been provided with information about entry processes and how to access the service including the requirement for a needs assessment at the point of their first enquiry to the service. The service operates twenty four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and new residents and their families. |

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

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

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

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

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

ARHSS D4.2

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has accepting/declining entry to service policies. Pre-approved residents seeking admission are not declined, providing there are vacant beds. The resident and or family/whanau are informed of the reason for declining entry if this should occur. Reasons for declining entry would be if there were no beds available or the service cannot provide the level of care. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Eight of eight long term resident files sampled (four hospital, four rest home) identified that the initial admission assessments, care plan summary and long term care plans are completed within the required timeframes by registered nurses. One of nine files (hospital respite) had the initial assessment and care plan completed by an RN on the day of admission. Service delivery is primarily undertaken by caregiving staff under the guidance of the registered nurses. Seven residents interviewed (three hospital and four rest home) and the ten family members interviewed (six hospital and four rest home) indicate that they are involved in the assessment and planning process.  D16.2, 3, 4: The eight long term files sampled (four hospital, four rest home ), evidenced that the care plan is reviewed by a registered nurse and amended when current health changes. Six monthly multi-disciplinary reviews are completed by the registered nurse with input from health care assistants, the GP, the recreation coordinator and any other relevant person involved in the care of the resident. Ten residents interviewed (four hospital and six rest home) stated that they and their family are involved in planning their care plan and at evaluation.  D16.5e: All eight long-term resident files reviewed (four hospital, four rest home), identified that the GP had seen the resident within 48 hours of admission. It was noted in the eight long term resident files (four hospital, four rest home), the GP had assessed the resident and documented the frequency for medical review to be between one to three monthly. The GP interviewed spoke positively about the service and describes very effective communication processes. The GP interviewed stated they are informed of any change in health condition in a timely manner as sighted in nine of nine residents' files reviewed  In all eight long term resident files (four hospital, four rest home), physiotherapy assessments, management plans and transfer plans are completed by physiotherapist. The recreation co-ordinator confirmed they complete the recreation and life style plan sections of the care plans.  The residents (three hospital, four rest home) and families (four rest home, six hospital) interviewed stated they felt their care needs were being met. Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Eight of eight long term resident files identified integration of allied health and a team approach.  Tracer Methodology -Hospital resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology: Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Assessment information is gathered from a variety of sources, including the resident, their family and allied health professionals, and a variety of assessment tools. Nine of nine resident files reviewed (five hospital and four rest home) evidenced appropriate assessment tools are used as a basis for care planning. A range of assessment tools were used including (but not limited to); Braden, nutritional screening, behaviour monitoring charts, continence diaries, food and fluid intake charts, falls risk assessments, mobility assessment, pain assessments, recreation and lifestyle assessment. All needs identified in the assessment process were included in the care plans.  Seven residents (three hospital and four rest home ) and ten families ( six hospital and four rest home) interviewed advised that they were involved in the development of the care plan and were aware that where appropriate, this information is shared with other health professionals involved with the residents care. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| In nine of nine care plans reviewed (five hospital and four rest home) the care plans are individualised and consumer focused. The care plans are current and there is evidence of changes to the care plan with a change in health status. Six monthly reviews and changes to resident’s health status are documented in the care plans of long term residents and signed by the registered nurse. There is evidence of the use of short term and long term care plans. The care plans are comprehensive and includes the outcomes from risk assessments.  In nine of nine care plans reviewed (five hospital and four rest home) there is evidence of resident and family involvement. Resident and families advised that they were involved in the development of the care plan. Staff use the care plan to ensure continuity of care delivery is maintained confirmed by the eight caregivers (four from the rest home and four from the hospital), two registered nurses (one from the rest home and one form the hospital). This is supported by external agencies providing input such as diabetic, psycho-geriatric or podiatry as well as a recreational and lifestyle plan providing an integrated approach. The health status report includes notes by GP and Allied Health professionals, significant events, communication with families and notes as required by RN. |

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Nine files were sampled (five from the rest home and four from the hospital). The care being provided is consistent with the needs of the resident as evidenced through interview with residents. Discussion with residents, family, HCAs, and registered nurses confirm that residents assessed needs are being met. There is evidence of three monthly medical review. Relatives are notified of changes in a resident's condition as evidenced in nine of nine resident files sampled (five from the hospital and four from the rest home) and ten of ten family members (four from the rest home and six from the hospital) interviewed. Staff write in residents’ progress notes on each shift and document any changes in care/condition of residents. Staff were observed accessing the care plans on the day of audit (three registered nurses, four care staff, recreation coordinator and one physiotherapist).  The eight caregivers (four from the rest home and four from the hospital), two registered nurses (one from the rest home and one from the hospital), the two care managers interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. Staff state that when something that is needed is not available, management provide this promptly. Sighted on the day of the audit were thermometers, a sphygmomanometer, a stethoscope, chair scales and blood glucose testing equipment. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted.   Seven residents and ten family members interviewed are complimentary of care received at the facility and felt they were well care for. During the tour of facility it was noted that all staff treated residents with respect and dignity, which was confirmed by the residents and families.  There are improvements required around wound management documentation, clinical observation post un-witnessed fall, documentation of pressure area interventions and documentation of risks of enabler use in the care plans. |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The care being provided is consistent with the needs of the resident as evidenced through interview with residents. Discussion with residents, family, HCAs, and registered nurses confirm that residents assessed needs are being met.  There is evidence of three monthly medical review. Relatives are notified of changes in a resident's condition as evidenced in nine of nine resident files sampled (five from the hospital and four from the rest home) and ten of ten family members (four from the rest home and six from the hospital) interviewed. Staff report pressure areas and any change in skin integrity to the RN on duty and complete and accident/incident form  pressure areas.  All falls are reported on the accident/accident form and evidence RN clinical assessment. Enablers in use (bedrails) are documented in the residents care plan. Monitoring occurs. Wound assessment and wound management plans are in place for sixteen of sixteen residents with wounds. |
| **Finding:** |
| (i)One pressure area reported on an accident and incident form has not been updated in the care plan or documented on a short term care plan; (ii) One long term resident’s care plan (rest home) does not have falls management strategies documented following reports of falls on accident and incident forms. The care plan evaluation for that resident states “no falls”. (iii) The progress notes and accident and incident form for a rest home resident documented an un-witnessed fall. Neurological observations were not completed as per the policy for un-witnessed falls (iv) Risks associated with enabler use (bedrails) is not documented on the assessment forms or the care plans in three of three resident files sampled with enabler use. (v) Sixteen of sixteen short term wound care plans did not have initial assessments completed that described the wound. Two of sixteen short term care plans for wounds had not been transferred onto the chronic wound care plan after three weeks. Sixteen of sixteen short term care plans for wounds do not have documented evaluation of the wound healing progress at each dressing change. |
| **Corrective Action:** |
| (i)Ensure pressure area interventions are documented in the care plan. (ii) Ensure neurological observations are completed as per policy. (iii) Ensure risks associated with enabler use is documented in the care plan. (iv) Ensure wound management documentation is completed as per policy |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| A recreation coordinator works 38 hours per week. There are recreational programmes running that are meaningful and reflect ordinary patterns of life. On the day of audit, residents were observed participating in a variety of activities. There is evidence of the wider community involvement with outings each week to local places of interest, visits to the local library, guest speakers, monthly church services, inter - rest home bowls competitions, and pre -school groups visiting. Entertainers come to the facility twice a month and 11 volunteers provide regular support to the programme. Residents and families interviewed report satisfaction with the activities programme.  The recreation coordinator is responsible for the resident’s individual recreational and lifestyle plans which are developed within the first three weeks of admission. The resident/family/whanau, as appropriate, is involved in the development of the activity plan. The recreational plan and lifestyle plan identify the residents special needs, their likes dislike and past hobbies. The residents at Chalmers Elderly Care have an activity plan that is commensurate with their needs and functional capabilities. Frequent van outings are arranged. Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in indoor bowls, and an exercise programme. There is also a reminiscing, crafts, music and a variety of activities to maintain strength and interests. Seven residents (three hospital and four rest home) and ten family members (four from the rest home and six from the hospital) were satisfied with the programme and advised that participation is voluntary. Hospital and rest home residents were observed to be enjoying the activities programme. Residents are able to provide feedback and suggestions for activities at the quarterly resident meetings and annual resident satisfaction survey. The activities provided are in keeping with the strengths, interests and needs identified in each resident/s activities plan and include group activities and one to one activities for residents who have needs which cannot be met in a group setting D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at the same time as the care plan review. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Eight of nine resident files sampled (four rest home and four hospital) evidenced care plans which have been reviewed within the last six months. One of five hospital care plans was for a respite resident and there was no evaluation due. Support plans are reviewed and evaluated by the registered nurse at least six monthly. Improvement is required around the documented evaluation of wound care plans. (Link 1.3.6.1). Evaluations occur six monthly by the registered nurses with input from the GP, the HCAs, the resident, the family and the recreation coordinator. Changes in health status are documented in the progress notes and on the short term care plan if not considered a long term change of health. There is a three monthly review by the medical practitioner. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Referral to other health and disability services is evident in eight of nine files sampled (4 hospital and four rest home). One resident is a respite care client. Referral documentation is maintained on resident files. Referrals are initiated by the service using a referral to allied health and other services form. Referrals were evidenced to mental health services, speech and language therapist, orthopaedic surgeon ear nose and throat, podiatrist, physiotherapist, occupational Therapist, Ophthalmologist. Referral documentation is maintained on resident files. All nursing referrals are co-ordinated by the registered nurses.  D 20.1 Discussions with registered nurses (one rest home and one hospital) identified that the service has access to needs assessors, hospital geriatricians and rehabilitation services, Medlab, radiological services, hospital specialists, cultural organisations and social workers. Advocacy information is available in the facility. When a resident requires a referral to another service, the GP takes responsibility for this task. An explanation is given to the resident and their family/whanau are informed as appropriate.   Seven residents interviewed and ten family members interviewed) are aware of their options to access other health and disability services and are supported through this process. All confirm advice has been provided by the facility. |

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

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

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

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

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

ARC D21 ARHSS D21

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies for transfer or exit of the service which describes guidelines for death, discharge, transfer, documentation and follow up. There is a discharge or transfer of resident to another facility policy. All relevant information is documented and communicated to the receiving health provider or service. A DHB transfer form accompanies residents to receiving facilities with a transfer letter, with accompanying photocopied relevant documentation including medication charts. The registered nurses are available for any follow up or queries.  Seven residents interviewed (four rest home and three hospital) and ten family members interviewed (six hospital and four rest home) are satisfied that they are kept well informed in regard to referrals and/or transfer to hospital where this has occurred. Staff could describe the referral and or transfer processes and demonstrated an understanding of resident right to be informed. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management policies and procedures comply with medication legislation and the Medicines Care Guides for Residential Aged Care. Chalmers Elderly Care has appropriate safe medication storage facilities, to ensure that medications will be appropriately stored and safely managed.   The service uses four weekly Medico packs. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy.   Two medication rounds were observed. The registered nurse administering the medications observed the correct procedures and checks. The medications are kept in locked trolleys and then in locked medication rooms when not in use. Medication fridge temperatures are recorded according to the company policy.   Controlled drugs are stored in locked safes in each medication room. Only the registered nurses have access to controlled drugs and two people (one being an RN) sign out controlled drugs. The controlled drug register is well kept and aligns with legislative requirements. Weekly controlled drug checks are completed by registered nurses.  There is currently one resident self -administering medication. The resident has been assessed as being safe to self -administer medication and this is noted on the care plan. The registered nurse checks the medication has been taken as charted. The medication is kept in a locked cupboard.  18 resident medication files were reviewed (nine from the rest home and nine from the hospital). All medication charts reviewed identified that the GP had seen the resident and reviewed the medication chart three monthly and all medications had been signed for. Improvements are required in relation to the charting of PRN medication. |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| 18 resident medication files were reviewed 18 medication charts reviewed identified that the GP had seen the resident and reviewed (nine from the rest home and nine from the hospital) had evidence of three monthly reviews and all medications had been signed for. Medication charts are legible, and up to date. Medication charts have photo ID’s and allergies noted. |
| **Finding:** |
| 15 of 18 medication charts reviewed did not have indications for use for PRN medications documented. |
| **Corrective Action:** |
| Ensure all PRN medications charted have indications for use charted that are specific for that resident |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Food services policies and procedures manual is in place. There is a qualified cook on duty each day from 6am-3pm supported by with two morning kitchen hands (8am-3pm and 7-11am) and an afternoon kitchen hand (3.30-7pm) to serve tea. There is a five weekly summer and winter menu that is reviewed by the company dietitian. The company dietitian is readily available to the cook by email/phone for advice if required. The cooks receive peer support by teleconference bi-monthly and when all the PSC cooks meet annually.  All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of residents likes/dislikes and alternative choices are offered. The cook (interviewed) has discussed dietary needs with the family of an Indian resident to ensure the resident’s cultural preferences are met. The cook is informed of dietary changes such as high calorie/high protein diets for weight loss. Dietary needs are met including normal, soft, pureed, vegetarian and finger foods. The main meal is midday lunch. Any variations to the menu is recorded. The meals are delivered to the rest home and hospital in bain maries and served to the residents by kitchen staff. There are first and second serving times that ensures the meals are served at acceptable temperatures for the residents in the dining rooms. Serving times are known and displayed for the residents. Seven residents interviewed (three hospital and four rest home) comment very positively about the meals provided. Residents have the opportunity to provide feedback and suggestions on food services at the resident meeting. Specialised plates, cups and cutlery is available to promote resident independence at meal times. A recent quality initiative is the purchase of bright red plates and a finger food menu as per best practice to encourage residents with dementia to maintain their appetites. There is good communication between the cook and the clinical staff. The cook attends the 8am handover report and is kept informed of any resident’s dietary changes or needs.   The kitchen is well equipped with a good work flow. There is a walk-in chiller, freezers and fridges, combi-oven and gas hobs.  Hot food temperatures are monitored on each meal. Fridge and freezer temperatures are recorded twice daily. All facility fridges are monitored. All foods are date labelled. The dry goods are sealed, labelled and off the floor. Goods are rotated weekly with the delivery of food orders. Chemicals are stored safely within the kitchen. Personal protective equipment is readily available and observed to be worn correctly on the day of audit. Cleaning schedules (sighted) are in place and maintained. Contractors carry out the high ceiling, wall cleaning and grills every six months.  D19.2: staff have been trained in safe food handling, fire drills and other relevant in-service. The cook has almost completed the kitchen service apprenticeship which will also allow her to become an assessor for food safety and hygiene standards. |

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

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

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

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

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

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

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

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

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

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

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

#### Standard 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemical supplies are placed into locked storage on delivery. The maintenance person monitors the chemical use and distributes to the kitchen, cleaning and laundry areas for use. The chemical provider the chemicals, safety data sheets and chemical safety training as required. Wheelie bins are used within the facility to collect general waste and collected regularly by the council. Approved containers are used for the safe disposal of sharps. Staff have attended waste management and chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff and observed to be worn correctly on the day of audit. A chemical spills kit is available. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 18 October 2014. The facility is divided into wings called “cottages”. The interior is well maintained and provides a home-like environment with spacious communal areas and several seating areas with sea and garden outlooks. There is a maintenance request book that is checked and addressed daily by the maintenance person. There is a planned maintenance schedule that also includes monthly checklists such as fire safety, equipment checks and hot water temperature monitoring. Electrical equipment has been tested and tagged annually. Clinical equipment has been calibrated. There is safe access to external areas. There is adequate space to promote residents' mobility and freedom of movement. The site has its own vehicle which is regularly used for resident outings. Multiple equipment storage areas were observed and staff spoken to confirm there are adequate equipment storage areas. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequate communal toilets that are easily accessible and signed and three wings have ensuite toilets. Seven of seven resident interviews and eight of eight of caregiver interviews (from both areas) confirm there are adequate number of bathroom facilities in the facility. There are adequate disabled size bathrooms. Hot water is monitored monthly and kept under 45 degrees. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is adequate room in residents’ bedrooms for personal belongings and room for both staff and residents in the provision of safe care when using mobility and transferring equipment. Seven of seven residents interviewed (three hospital and four rest home) and eight of eight HCAs interviewed confirm there is adequate space in residents' bedrooms. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is good access for residents to lounges, quiet areas, and dining areas that meet the needs of the residents. Staff assist residents to access communal living areas as required and observed on the day of the audit. All seven residents interviewed confirm there are number of internal and external areas they are able to access for relaxation and staff assist them to access the lounges and the dining rooms if they require this. There are two main lounge areas to allow for activities, resident relaxation and provide privacy for residents and visitors. Each wing has a smaller lounge. The facility design allows for freedom of movement for all residents including those with mobility aids. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. There is a laundry manual available that includes the use of personal protective equipment, handling of linen, waste disposal and with hazard controls. The laundry and cleaning room is a designated area and clearly labelled. Chemicals are stored in locked cupboards. All chemicals are labelled with manufacturer’s labels. Safety data sheets are readily available. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. Fire drill was last completed on 4 April 2014. The fire service approved an evacuation plan on 1 Jan 1999.  D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Chalmers is well prepared for civil emergencies and has civil defence supplies readily available including torches and radios. There is a tank reservoir of water for use in an emergency. A barbeque is available for cooking. There is emergency food supplies sufficient for three days. There are other products for at least three days such as incontinence products and personal protective equipment. There is a store of supplies necessary to manage a pandemic. Two generators have been purchased for use in an emergency and training provided in the use of the generators.  There is an appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, communal toilets, ensuite toilet/showers, lounges and dining rooms. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The call bell system including the door bells are connected to pagers. The facilities are secured at night. Seven residents interviewed stated their bells are answered in a timely manner. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

An appropriate 'call system' is available to summon assistance when required.

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

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

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

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

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

ARC D15.2f ARHSS D15.2g

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Chalmers Elderly Care is light, centrally heated and with an ambient temperature that is maintained to ensure it is comfortable. Resident’s rooms have access to natural light with external windows and there is adequate external light in communal areas. Smoking is only permitted in the designated area. |

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

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

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

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

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

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and review of restraint use. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. The service currently has a restraint-free environment. Approval is required from the PSC Nurse Director for implementation of a restraint. There are currently 18 bedrails in use as enablers only (17 hospital and one rest home). There is an enabler co-ordinator for the service. Enabler consent, assessment and reviews are in place for the three resident files sampled for enabler use. An online enabler register is maintained. Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. There is provision for the use of an emergency enabler. Risks associated with the use of enablers have not been identified in the assessment or linked to the long term care plan (link 1.3.6.1). Enabler co-ordinators within the PSC group meet twice yearly and have telephone conference resources available. Restraint minimisation is included in the HCA study days. |

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a QPS benchmarking system in place. The scope of the infection control programme policy and infection control programme description is available. There is an established and implemented infection control programme that is linked into the risk management system.  The infection control coordinator is the Quality co-ordinator (registered nurse) and she works closely with the staff. The infection control co-ordinator provides a monthly report to the quality committee. The committee and the governing body are responsible for the development of the infection control programme and its review. Staff are well informed about infection control practises and reporting. They can contact the RN or infection control co-ordinator if required and concerns can be written in progress notes and the communication book. For after hour’s requirements there is an RN on duty 24/7 and the infection control co-ordinator is available if required. Suspected infections are confirmed by laboratory tests and results are collated monthly. Each quarter statistics are sent to the Australian QPS benchmarking programme. Summaries/graphs of these results are feedback to Chalmers and compared with other PSC homes of similar size and service.  There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection.  There is a risk factors for nosocomial infection policy, an accidental infectious exposure, TB, management of staff found positive for MRSA, guidelines for staff visiting overseas, risks and exposures for the pregnant healthcare worker, work restrictions for healthcare personnel exposed to or infected with infectious diseases, handling deceased residents with communicable diseases, guidelines for isolation, transferring of residents with an infection , isolation policy, and procedure for when an outbreak of infection occurs. There is evidence (signage) of preventative measures in place to prevent resident exposure to infectious diseases such as Norovirus. The infection control co-ordinator has been monitoring the incidence of herpes zoster (shingles) in residents and has identified in consultation with the GP the benefits of offering the new herpes zoster vaccine to residents. A letter has been sent out to families however advised, it is too early to gauge resident and family response. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The quality committee is made up of a cross section of staff from all areas of the service including; management, clinical, kitchen, cleaning, laundry and maintenance. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control policies and procedures are developed and reviewed by an external infection control specialist. The manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff.  Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI’s, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases. There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, waste disposal, notification of diseases and educational hand-outs. |

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control co-ordinator has maintained her skills and knowledge of infection control practice through attendance at the annual PSC infection control nurse peer support day which included a variety of speakers including Bugs Control and DHB speakers. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, G.P's, and expertise within the organisation and external infection control specialists.  The infection control co-ordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and HCA study days that are held annually. The infection control co-ordinator attends all site meetings and provides topical education which is documented in the meeting minutes. Staff meeting minutes February 2014 documents discussion around the wearing and changing of gloves in-between residents care to reduce the incidence of eye infections.  Resident education is expected to occur as part of providing daily cares. There is evidence of consumer and visitor education around influenza and norovirus. A family letter has been sent out recently regarding information on the new herpes zoster vaccine. |

##### **Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available. Individual resident infection control summaries are maintained.  The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility. All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.  Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.   An example of identifying trends and corrective action is for November 2013 there were nine eye infections in the hospital area. It was identified all nine residents were dependent residents for all cares. Visual observations identified an improvement required around the wearing and changing frequency of gloves in-between residents. The infection control co-ordinator (interviewed) stated that with infection control reminders and changes in practice the eye infections numbers dropped to two for the month of December (one hospital and one rest home). The staff are kept informed regarding infections, trends, corrective actions and outcomes as sighted in February 2014 staff meeting minutes. |

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

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

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

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

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

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