Orewa Secure Care Limited

Current Status: 8 May 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

The Orewa Secure Care provides rest home, hospital and secure specialist dementia level of care for up to 29 residents. The service has a secure specialist dementia unit for 15 residents and a rest home/hospital section for 14 residents.

There are no areas for improvement identified at this audit and two areas recognised for the organisation's commitment to continuous improvements. These two areas are related to the implemented clinical governance system and the interventions to manage unexplained weight loss.

Audit Summary as at 8 May 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 8 May 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 8 May 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 8 May 2014

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

Safe and Appropriate Environment as at 8 May 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 8 May 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 8 May 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 8 May 2014

Consumer Rights

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

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

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

Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The organisational governance systems for clinical care, staffing, operational and financial aspects of the service are monitored on a monthly basis through the services clinical governance system. This system of monitoring is rated beyond the full attainment level and has gained a continuous improvement rating.

The service is managed by an appropriately experienced and qualified registered nurse (RN) who is responsible for the overall running of the service. There is also a clinical manager (RN) to provide additional clinical direction to the staff. The manager reports to the owner of the service.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place, which is linked to the clinical governance monitoring and reporting system for the early identification of potential areas that can be improved. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There are sufficient policies and procedures which describe all aspects of service delivery and organisational management.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery to the rest home, hospital and specialist dementia care unit. Rosters sighted document an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's

contract with the district health board and standards for safe staffing in aged care and dementia care. The education programme is available for all staff and education records document staff attendance.

Resident information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of Service Delivery

Orewa Secure Care has pre-entry and entry services which are organised by the nurse manager and clinical manager. These processes are supported by policies and entry information. Included, is the referral process, with assessments being performed by the Needs Assessment Co-ordination Service.

The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the general practitioner (GP) along with other health service providers. The system of assessing, monitoring and implementation of interventions for the management of unexplained weight loss is rated beyond the full attainment level and has gained a continuous improvement rating.

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

The activities programme is overseen by one activities co-ordinator who works a total of 30 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.

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

Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and specialist dementia level of care. All areas ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, and is in a setting appropriate for the residents. Residents, visitors, and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.

All buildings, plant, and equipment complies with legislation. The building has a current building warrant of fitness. Documented systems are in place for essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained. There is an ongoing maintenance plan to address the upkeep of the building.

The facility has an appropriate call system for residents to request assistance from staff. Residents have access to external gardens and an internal courtyard. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. The secure specialist dementia unit is separated from the rest home/hospital section.

Residents are provided with adequate toilets, showers, and bathing facilities. There is a mix of shared ensuites and common facilities conveniently located throughout the service. Residents are assured of privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Restraint Minimisation and Safe Practice

There is no restraint or enabler use in the specialist dementia unit. This unit is designed to allow maximum freedom of movement while promoting the safety of residents that are likely to wander. The current approved restraints at the service are bed rails and lap belts. There are three residents requiring the use of bed rails or lap belt, in the rest home/hospital section at the time of audit. There are no residents with enabler use. The service maintains processes for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use. An assessment of residents is undertaken in relation to use of restraints to ensure the appropriateness of the restraint device. Restraints are used safely, with ongoing review, assessment and evaluation to ensure restraint is used to maintain safety for the residents. The service demonstrates the continued quality review of their use of restraint. There is a documented monitoring and observing process when lap belts and bed rails are used.

Infection Prevention and Control

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

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

HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

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

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

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

Audit Report

Legal entity name:	Orewa Secure Care
Certificate name:	Owera Secure Care

Designated Auditing Agency:	DAA Group

Types of audit:	Certification
Premises audited:	Orewa Secure Care, 163 Hibiscus Coast Highway, Orewa.
Services audited:	Hospital, rest home, rest home including dementia care
Dates of audit:	**Start date:** 8 May 2014 **End date:** 9 May 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:	29

Audit Team

Lead Auditor	XXXXX	**Hours on site**	16	**Hours off site**	8
Other Auditors	XXXXX	**Total hours on site**	16	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52

Number of residents interviewed	2	Number of staff interviewed	9	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	23	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Friday, 6 June 2014

Executive Summary of Audit

General Overview
The Orewa Secure Care provides rest home, hospital and secure specialist dementia level of care for up to 29 residents. The service has a secure specialist dementia unit for 15 residents and a rest home/hospital section for 14 residents (two rest home and 12 hospital residents at the time of audit). There are no areas for improvement identified at this audit and two areas recognised for the organisation's commitment to continuous improvements. These two areas are related to the implemented clinical governance system and the interventions to manage unexplained weight loss.

Outcome 1.1: Consumer Rights
Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Residents and their families are informed of their rights at admission and throughout their stay. Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service. Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services. Evidence is seen of informed consent and open disclosure in residents' files reviewed. Communication channels are clearly defined and interviews and observation confirm communication is effective. There is a complaints policy which details residents and their family members have a right to make a complaint. Residents and family members interviewed confirm they are provided with information on the organisation's complaints process. A complaints register is maintained which details dates of complaints and actions undertaken.

Outcome 1.2: Organisational Management
Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The organisational governance systems for clinical care, staffing, operational and financial aspects of the service are monitored on a monthly basis through the services clinical governance system. This system of monitoring is rated beyond the full attainment level and has gained a continuous improvement (excellence) rating. The service is managed by an appropriately experienced and qualified registered nurse (RN) who is responsible for the overall running of the service. There is also a clinical manager (RN) to provide additional clinical direction to the staff. The manager reports to the owner of the service. The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme is in place, which is linked to the clinical governance monitoring and reporting system for the early identification of potential areas that can be improved. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There are sufficient policies and procedures which describe all aspects of service delivery and organisational management.

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

Resident information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Outcome 1.3: Continuum of Service Delivery

Orewa Secure Care has pre-entry and entry services which are organised by the nurse manager and clinical manager. These processes are supported by policies and entry information. Included, is the referral process, with assessments being performed by the Needs Assessment Co-ordination Service.

The residents' records reviewed demonstrate evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals are reviewed on a regular basis with the resident and/or family/whanau input. The provider works with the general practitioner (GP) along with other health service providers. The system of assessing, monitoring and implementation of interventions for the management of unexplained weight loss is rated beyond the full attainment level and has gained a continuous improvement (excellence) rating.

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

The activities programme is overseen by one activities co-ordinator who works a total of 30 hours a week. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. The programme is displayed monthly and staff encourage residents to attend.

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

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the rest home, hospital and specialist dementia level of care. All areas ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, and is in a setting appropriate for the residents. Residents, visitors, and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Residents are provided with safe and hygienic cleaning, laundry and waste management services.
All buildings, plant, and equipment complies with legislation. The building has a current building warrant of fitness. Documented systems are in place for

essential, emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained. There is an ongoing maintenance plan to address the upkeep of the building.
The facility has an appropriate call system for residents to request assistance from staff. Residents have access to external gardens and an internal courtyard. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. The secure specialist dementia unit is separated from the rest home/hospital section.

Residents are provided with adequate toilets, showers, and bathing facilities. There is a mix of shared ensuites and common facilities conveniently located throughout the service. Residents are assured of privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Outcome 2: Restraint Minimisation and Safe Practice

There is no restraint or enabler use in the specialist dementia unit. This unit is designed to allow maximum freedom of movement while promoting the safety of residents that are likely to wander. The current approved restraints at the service are bed rails and lap belts. There are three residents requiring the use of bed rails or lap belt, in the rest home/hospital section at the time of audit. There are no residents with enabler use. The service maintains processes for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use. An assessment of residents is undertaken in relation to use of restraints to ensure the appropriateness of the restraint device. Restraints are used safely, with ongoing review, assessment and evaluation to ensure restraint is used to maintain safety for the residents. The service demonstrates the continued quality review of their use of restraint. There is a documented monitoring and observing process when lap belts and bed rails are used.

Outcome 3: Infection Prevention and Control

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

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	The achievement of the clinical governance system is beyond the expected full attainment and beyond that of comparable sized organisations. The project, review and evaluation of the clinical governance system involved a review process which includes the analysis and reporting of findings. There is evidence of action taken based on findings and improvements to service provision; this includes the implementation and revision of clinical management systems. The residents' safety is measured through the balanced scorecard system and is demonstrating positive impacts on safety outcomes (eg, increasing weight gain for resident with unexplained weight loss). The results of the outcomes are fed back to staff and the owner.
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	CI	The weight management programme goes beyond meeting the standard as it includes the prevention of secondary illness giving the opportunity for longer life expectancy. The operational benefits are identified and as are the cost benefits.

Code	Name	Description	Attainment	Finding
		needs, and desired outcomes.		

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: Hospital, Dementia and Rest Home: The nine staff interviewed (one RN, five caregivers, one cook, one cleaner, one laundry, one activity coordinator) are able to demonstrate their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation. It is also included in the annual in-service education programme (2014 education schedule sighted). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). The five relatives and two residents report on interview that they are treated with respect and understand their rights. ARRC requirements are met.

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: Stage one: The consumer rights policy outlines service requirements to meet resident rights within the facility. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (confirmed by interview with the Clinical Manager). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held as part of the annual education programme (evidence sighted). The Nationwide Health and Disability Advocacy Services information is included in the Resident Information Pack given prior to or on admission to the service and further information, including contact details, is available to residents and their families at the entrance to the facility (sighted). This information is also given to new residents and their family. ARRC requirements are met.

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: Stage One: Policy identifies staff responsibilities related to privacy. There is policy covering resident's safety and abuse prevention and security. This is detailed and identifies what staff should do if they suspect any issues. The residents' safety and abuse prevention policy is comprehensive, provides appropriate definitions of abuse, describes signs of abuse and neglect, different staff roles and responsibilities and prevention strategies. The facility has single rooms (except for one couple room) only and this provides adequate and private areas. Privacy is maintained by undertaking meetings and discussions in the single rooms. Education on privacy takes place at orientation and during in house education. The nine staff and one Clinical Manager interviewed understand the residents' rights to dignity, respect and privacy. Residents are addressed in a respectful manner and by their preferred names (confirmed in interviews with two of two residents and five of five family members). Residents are encouraged by staff to be as active as is safely possible (confirmed in interviews with two residents and five family members). ARRC requirements are met.

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: Stage one: The service has cultural safety guidelines for staff to enhance their practice and approach to Maori residents and whanau. The service uses the four corner stones of Maori health to assess and deliver services (te taha tinana, te taha wairua, and te taha hinengaro and te taha whenua). The importance of whanau is described as crucial to resident's wellbeing and the service actively encourages, supports and includes whanau in all aspects of care and decision making. Policy states that resident's cultural beliefs are ascertained upon admission via assessment and documented on the resident's care plan. A specific assessment plan for Maori residents is sighted. The business plan identifies that the service liaises with Te Haa, Wellford as required to ensure strategies in place meet Maori resident needs. There are no maori residents at Orewa Secure Care, at the time of audit. ARRC requirements are met.

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:

Stage one: The cultural responsive – other cultures policy has the documented objective to meet culture values and beliefs of our residents, their family and our staff. There are general guidelines to assist staff in the assessment and delivery of services that will meet resident cultural and spiritual needs. This includes the use of interpreter services as required. Residents receive services that take into account their cultural and individual values and beliefs. On-going resident satisfaction surveys monitor this as part the information collected. The one resident of Maori culture and her family are satisfied with the services provided.

Policy identifies that the resident's choice of representative is accepted by the service. Residents are consulted regarding their cultural beliefs and values during their admission. The six care plans reviewed evidence is seen of cultural beliefs and values being identified by the resident and/or family whanau. Staff receive cultural education at orientation and as a regular in-service education topic.

ARRC requirements are met.

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: Staff report any inappropriate behaviour as confirmed in nine staff interviews, one manager and one clinical manager. The two resident and five family interviews report they are comfortable to speak directly to the manager or clinical manager and have no concerns. ARRC requirements are met.

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 clinical manager maintains a record of her education and evidence is seen of regular attendance at the Waitemata District Health Board (WDHB) integration with residential care education programme. Evidence is seen of caregivers undertaking regular in-service education which meets all requirements. There is evidence in the annual education plan that education provided to staff ensures a commitment to good practice. The six staff files reviewed show evidence of education attendance. ARRC requirements are met.

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: The two residents and five families confirm communication with staff is open and effective (verified in interviews). There is evidence in the six resident files reviewed that family are contacted following incidents (eg, falls) and involved in annual multidisciplinary meetings. Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with nine of nine clinical staff and the manager and CM). There is sufficient space in each single room to permit private discussions. Processes are identified in the Interpreter Policy. If necessary, an interpreter within the community is sought (confirmed in interview with the CM). ARRC requirements are met.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)
Consumers have a right to full and frank information and open disclosure from service providers.

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

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)
Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)
Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

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

Attainment and Risk: FA
Evidence:
Stage one: Policy clearly describes that gaining consent for all actions is voluntarily and must be given without inducement, force, duress or coercions. It includes advance directives and living wills which can only be completed by the resident. Information in policy identifies the resident's right to make an informed choice and give

informed consent, the right to be fully informed and the right to effective communication.

Written consent is obtained as required and in all six residents' files reviewed evidence is seen of consent gained for outings, photo identification and medication. Informed consent procedures are evaluated, recorded and reviewed to monitor effectiveness. Separate written consents are obtained for disclosure of resident information and restraint use.

Residents' choices and decisions are documented in their care plans and acted on (confirmed in six of six residents' files and interviews with two residents and five relatives).

Verbal consent is obtained prior to an intervention being carried out or by telephone with the family (confirmed in interview with two residents and five family members). Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process (confirmed in interviews with nine staff and the CM). Staff give a full explanation of the proposed treatment, including any risks, prior to consent being obtained. Written consent is obtained where risk is involved (eg, use of restraint). Staff, residents and their family/whanau understand that consent can be withdrawn at any time (confirmed in interviews with two residents and five families).

ARRC requirements are met.

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: Stage one: Throughout policies sighted it is identified that the resident's right to advocacy and the support person of their choice is recognised by the service. The Residents Rights Policy identifies the consumer's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner's office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons (confirmed in interview with two residents and five relatives). Evidence is seen of in-service education for all staff relating to advocacy and support in the 2014 programme. ARRC requirements are met.

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: There are telephones available in the lounge/hall area for residents to call family/whanau or receive calls from family/whanau members or in there room should they wish to have their own telephone. There is also a portable phone which is taken to the residents as required. Interviews with family and residents confirm the ability to contact family and they confirm they are contacted by staff as needed. Policy includes procedures to be undertaken to assist residents to access community services. Residents are supported if they wish to access community services. Activities include regular outings with families and community visits to the facility (evidenced in interview with the manager, CM and the activities coordinator). ARRC requirements are met.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)
Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk:	FA

Evidence:

Stage one: The sighted complaints policy, flow chart and complaints process as documented on the complaints form complies with Right 10 of the Code.

The service has an up-to-date complaints register which identifies the date of the complaint, type of complaint and the actions taken and when resolved. There are no outstanding complaints regarding the service at the time of audit. Two complaints sampled for 2014 indicate the complaints were investigated within the time frames of Right 10 of the Code. The service has one external anonymous complaint that the DHB investigated with an onsite visit in December 2013 in which the claims in the complaint were unsubstantiated. Complaints management is used to improve services as appropriate.

Two of two residents and five of five family/whanau interviews confirm they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. They state they would feel comfortable to make a complaint at any time. The information given to all residents and family/whanau upon admission includes complaints forms and a full explanation of how the system works. Advocacy information is also included in the admission booklet. Both complaints and advocacy information is on full display at the entrances to the facility.

Interviews with nine of nine staff confirm awareness of their responsibility to record and report any complaints they may receive.

The ARRC requirements are met.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The business plan informs the decision made in policy and budgeting. It identifies the organisation's mission statement, vision and philosophy and shows the organisation's planning process to meet residents' needs. The quality policy statement identifies the mission of the organisation and the procedures undertaken to achieve the mission statement. Actions described include the use of quality programmes and procedures, identification of hazards, staff training and education, data reporting of incidents/accidents, infections and internal audit results to identify trends and improve services. The plan is reviewed annually to identify goals attained.

Stage two: The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. The goals are reviewed monthly using the clinical governance system and balance scorecard. Refer to criteria 1.2.1.1

The service is managed by a suitably qualified and experienced facility manager who is registered nurse (with annual practising certificate sighted). The facility manager has over 17 years of experience in the management of aged care services and has pervious managed aged care services operated by large multisite providers. The manager has a job description that described authority, accountability, and responsibility for the provision of services (sighted). The manager has completed over 8 hours education in the previous 12 months related to the management of aged care. The manager completes a professional portfolio and maintains professional knowledge through ongoing education. This includes attendance at aged care conferences, local assessments, health care auditing course, first aid recertification and specific education related to aging processes and illness. The manager provides a monthly balance scorecard to the owner. The manager is support by a clinical team, which has a clinical manager registered nurse (RN) and other registered nurses.

The nine of nine staff and GP report the service is managed very well. The owner interviewed has full confidence in the experience and skill of the both manager and clinical manager to effectively perform their roles.

The ARRC requirements are met.

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

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

Attainment and Risk: CI

Evidence:

The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed on a monthly basis using the clinical governance system. The service has conducted a project on the clinical governance systems. The project involved the review of the systems used at Orewa Secure Care and review of industry best practice. The clinical governance system was developed by the manager in 2007 and last updated, reviewed and evaluated to meet the specific needs of Orewa Secure Care in October 2013. The system provides both qualitative and quantitative results giving an objective and statistical perspective on the governance and clinical aspects of the organisation. The tool utilizes the balanced scorecard and benchmarking targets for local, organisational, staffing and financial aspects of the organisation. The clinical components reviews falls, urinary tract infections (UTIs), total infections, new pressure areas, undiagnosed depression, unexpected weight loss, skin tears and pain management. The system provides early warning systems to allow support to manage areas of concern in a pre-emptive way rather than reactively. The results

are reported and evaluated each month with targets set for the following month. From the review of the clinical governance systems the service developed and implemented a revised weight management system. Review of the balance scorecard in April 2013 for unexplained weight loss identified that five residents had unexplained weight loss. With the interventions implemented, all five residents had gained weight (also refer to CI at 1.3.6).
Finding: The achievement of the clinical governance system is beyond the expected full attainment and beyond that of comparable sized organisations. The project, review and evaluation of the clinical governance system involved a review process which includes the analysis and reporting of findings. There is evidence of action taken based on findings and improvements to service provision; this includes the implementation and revision of clinical management systems. The residents' safety is measured through the balanced scorecard system and is demonstrating positive impacts on safety outcomes (eg, increasing weight gain for resident with unexplained weight loss). The results of the outcomes are fed back to staff and the owner.
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: During a temporary absence a suitably qualified and/or experienced person performs the clinical manager's role. The clinical manager's (RN) job description includes

taking on the role of manager during the manager's temporary absence. The clinical manager maintains a professional portfolio. The clinical manager interviewed demonstrated knowledge and skills to perform the manager's role during temporary absences (confirmed at interview with the clinical manager, manager and owner).

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The quality and risk plan is a generic document that identifies the process for risk identification, controls and on-going actions required to limit identified risks. Risk categories include consumer focus, provision of effective programmes, certification and contractual requirements, risk management, and continuous improvement. It identifies generalised goals and objectives and who is responsible and the measure used to identify how the controls are effective or responsive to resident needs.

Stage two: Family and resident feedback is sought through satisfaction surveys; for 2013 outcomes of surveys provide positive feedback on the provision of services. The results of the surveys are displayed on the notice board.

The service has implemented a clinical governance system (refer to 1.2.1) for an integrated approach to quality and risk management. On-going with the monthly monitoring of the clinical, operational, financial and staffing risks through the balanced scorecard the service also has an internal auditing system. There is a monthly report which includes infection control, health and safety, hazards, restraint, complaints, staffing changes, care planning, environmental matters, equipment, maintenance, education, staff meeting outcomes and quality improvements. All information is taken to the full staff meeting as identified in minutes sighted. All data is trended and trends are analysed by the management team and corrective action plans are developed as required. Results of trends and required corrective actions are discussed at the monthly staff meetings as confirmed by staff and management interviews and in minutes sighted.

The monthly RN, management and staff meetings monitor the services achievements against the organisation's quality and risk management plan and reports progress to both the owners and at staff level. Required corrective actions are discussed and reviewed at all meetings as confirmed in minutes sighted.

Interviews with three of three caregivers and one RN confirm they are aware of quality systems and that they are informed of audit results at staff meetings. Staff confirm that open discussion occurs related to all quality and risk issues and those meetings are used to measure quality improvement outcomes (sighted in meeting minutes).

Staff discussions, regular internal audits, quality and risk data evaluation and consumer surveys are used to indicate achievement measurements. Documentation identifies that corrective actions are put in place as required and evaluated to see if they have improved service.

Corrective actions are put into place to address identified areas for improvement as appropriate. Corrective action plans sighted cover all aspects of service delivery and they are discussed at all levels of the organisation. Corrective actions are developed as a result of identified trends from monthly data collation, internal and external audit results, deficits identified by staff during meetings, as a direct result of consumer survey results and from complaints received. Corrective action plans sighted have measurable outcomes and they are evaluated in a timely manner. Corrective actions are clearly written and easy to follow.

The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes. Interviews with three of three caregivers confirm their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards is set out in the information book given to all residents and family/whanau members.

Monthly staff and management meetings have trended data and benchmarking results presented as part of the standing agenda. The trending is also captured in the monthly balanced scorecard. Meetings are used to review corrective actions put in place. The owner receives monthly feedback and reports of any areas of concern identified in the balanced scorecard and monthly target. The report documents the area of concern, actions taken and the follow up and review of the actions implemented.

There is a document control system to manage the policies and procedures. The policies are updated at least two yearly, or earlier if there are legislative changes. New and updated policies are displayed in the staff office and tabled at staff meetings. Staff only have access to current policies and procedures, with obsolete documents removed from staff access.

Two of two residents and five of five family/whanau interviews confirm any issues that are raised are addressed promptly and that they are kept informed of the outcome. Satisfaction survey results confirm interview findings.

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: Stage one: Policy related to accidents and incidents states that all adverse, unplanned or untoward events are systematically recorded, investigated and analysed. The staff and management interviewed understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The manager reports that there have been no serious incidents that have required essential notification. The service uses health and safety report forms to document adverse, unplanned or untoward events or near misses. This information is monitored, evaluated and benchmarked on the monthly balance scorecard. The monthly reports of the incidents and accidents record the number incidents and accidents. Shortfalls identify opportunities to improve service delivery and manage risk, this includes implementing strategies at the increased times of falls. Results of incident and accident trend analysis are discussed at the monthly staff and management meetings and reports are presented to the owners as appropriate (eg, if there is serious injury). Interviews with three of three caregivers and the members of management confirms their understanding of the need to document all adverse events. The two of two residents and five of five family/whanau member interviews, and documentation sighted on incident/accident forms in seven of seven residents' files, confirms family/whanau are kept well informed of their relatives care requirements and are contacted appropriately by the service if there are any concerns. The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Stage one: Human resources policies describe good employment practices that meet the requirements of legislation. Ongoing training is provided and expected to ensure this safety. The employed registered nurse holds a current practising certificate. Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The manager ensures that staff who require practising certificates have them validated annually. Practising certificates are sighted for all staff who require them. Human resources practices are implemented as per policy requirements and five of five staff record reviews (two RNs, two caregivers and one cook) identify that staff are employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate. The service undertakes regular in-service staff education which is well documented and identifies that guest speakers/educators along with current RNs present education. (Content of education sighted). Staff confirm during interview that they have access to external education/training and this is highlighted in five of five staff file reviews. Each staff member has a clearly identified education attendance record. Staff appraisals are up-to-date and used as a method for staff to identify educational needs, wants and interests. Education sighted covers all key components of service delivery. Caregivers are encouraged and supported to undertaken the national certificate for the older person, which includes dementia care. All staff who work in the specialist dementia unit are enrolled or have completed the required national standards in dementia care. The two of two residents and five of five family/whanau interviews and the 2013 resident/relative satisfaction survey results sighted confirm services are delivered in a manner to meet required needs

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)
Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)
New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Stage one: The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs and contractual requirements with the DHB. Stage two: The care staff rostering and skill mix is based on clinical indicators for safe staffing in aged care and dementia care. A roster review was conducted in January 2014, which evidenced staffing ratio and numbers are in excess of the safe staffing indicators. The manager is onsite Monday to Friday. The rosters sighted confirm that there is at least one RN on duty at all times. The RN provides coverage to the rest home/hospital and dementia unit. The care staff roster is as follows: -Rest home/hospital section (maximum of 14 residents); there are two caregivers on morning shift, one and a half (shorter shift) caregivers on afternoon shift and one caregiver on night shift. -dementia unit (maximum of 15 residents); there are two caregivers on morning shift, one and a half caregivers (shorter shift) on afternoon shift an one caregiver on night shift. There are adequate numbers of support staff that include administration, cook, and kitchen cleaning staff, a maintenance person and an activities coordinator.

The GP interview confirms there is a system in place for after-hours medical services. Interviews with five of five caregivers (two who work morning and afternoon shift and one who has worked night duty) confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. This is supported by interviews undertaken with the two of two residents and five of five family/whanau members.

The ARC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. On admission the admission details and unique identification NHI for each resident is obtained. All six files (three hospital, two dementia and one rest home) sighted have accurate and timely information entered into the residents care and administration file.

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The resident’s files are securely stored in a locked cabinet in the staff office areas. Archived records are stored securely on site, these are retrievable as required.

All residents’ records are legible and the name and designation of the service provider is identifiable, as confirmed in the six of six residents files reviewed. The service uses a mix of paper based and electronic assessment and records. Any electronic records are password protected and secure log in is required to access resident information. All records pertaining to individual residents are integrated, as sighted for the six of six residents files reviewed.

The relevant ARRC requirements are met.

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

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

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

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

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

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)
All records are legible and the name and designation of the service provider is identifiable.

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the home. The NZACA standard Resident's Services Agreement is the admission agreement that is used. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative. The two residents and five family members report that prior to admission meetings are held with the nurse manager or clinical manager regarding the admission agreement and they had full understanding of the requirements. The nine staff interviewed each have a role they undertake with new residents (eg, the cook explains the menu). ARRC requirements are met.

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: Policy identifies that prospective residents may be refused entry if at any time the nurse manager and clinical manager feels that an applicant or existing resident is not

suitable. The manager reports that family and referral agency will be officially informed with reasons stated for decline. This process is described in the policy and acknowledges that family/whanau and the referral agency are informed of the reason for declining entry to service. The manager reports that they have a close working relationship with the needs assessors at the WDHB and the resident's suitability for admission is discussed prior to the family visiting.

ARRC requirements are met.

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:

On admission all residents are introduced by the nurse manager and admitted by the Clinical leader (CL). The GP contracted to the facility visits within 48 hours of admission for medical and medication assessment. The CL oversees all care planning, evaluations, and signing off on the documentation. All documentation is reviewed within required timeframes. There is a system in place that identifies all progress notes are to be completed by the RN or caregivers at the conclusion of each duty. This ensures that every resident's progress notes are documented in each duty.

Clinical risk tools for falls, pressure area and mental capacity are all completed as part of routine admission. Falls are monitored as part of the quality process and any risks identified. These are discussed and actioned at staff meetings and become part of the quality process.

The caregivers attend both in-house education and fifty percent of caregivers have completed the National Certificate in Care of the Elderly through Careerforce (sighted). All six files (three hospital, two dementia and one rest home) reviewed show evidence of resident or family/whanau consultation. This includes two residents and five family members who report during interview that they are consulted regarding their service provision.

Tracer Methodology Rest Home:
XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

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

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

ARRC requirements are met.

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:

Stage one: The clinical management policy identifies resident needs are ascertained through the assessment process. This includes continence, hygiene and personal grooming, skin management and wound management.

The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and mental assessment. Referral letters are sighted from external agencies, including WDHB clinics, and there is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all six (three hospital, one rest home and two dementia) files reviewed that assessments are conducted within the specified timeframes. In all six files reviewed the assessment information is used as part of care plan development. The clinical staff interviewed report knowledge of clinical tools and when they are to be used.

ARRC requirements are met.

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 all six files reviewed (three hospital, two dementia and one rest home) evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and mental capacity. Clinical risk tools are used as part of the intervention process and towards measuring achievement of desired outcomes. All health professionals document in the resident's individual clinical file and have access to care plans and progress notes. Documentation in all six files reviewed include nursing notes, medical reviews and hospital correspondence. The manager, clinical manager or RN accompanies the doctor on their rounds and documents the outcome in the residents' progress notes. The GP documents in the notes or by computer and sends to the facility to be filed in the resident's notes. Evidence is also seen of letters from WDHB clinics. The care plan is written in a language that is user friendly and able to be understood by all staff. Care staff are told of any changes in the care plans at changeover of shifts. In all six residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. ARRC requirements are met.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)
Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)
Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA
Evidence:
In all six files reviewed there is evidence of the interventions relating to the residents' assessed needs and desired outcomes. The nine clinical staff interviewed report they are informed of all care plan issues at hand over and have relevant in-service education if required.

In all six residents' files reviewed there is evidence of referrals from the WDHB, including Mental Health Services for the OIder Person (MHSOP) and diabetic clinic. The two residents and five relatives interviewed report that they are satisfied with the external contacts for any health issues and other personnel that are available when required.

The education programme implemented at Orewa Secure Care includes in-service education on diabetes, challenging behaviour and manual handling.

A CI is recommended for the Weight Management Programme implemented at Orewa Secure Care.

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: CI
Evidence: The 'Weight Management Programme' addresses weight loss in the elderly which is a significant issue in aged residential care. As part of the programme the weight loss in the elderly is managed by frequent weight monitoring (including risk rating), weight variances and access to interventions. The programme offers protection for medical risk (eg, infection, depression and premature death), operational risk (eg, complaints, reputation and wound management cost). The outcomes are healthy weight management, multidisciplinary intervention resulting in successful weight management, and medical intervention for early diagnosis. Additional benefits are relative satisfaction, staff compliance and bed day cost control. The programme is cost effective and provides for the facility to become a centre of excellence.
Finding: The weight management programme goes beyond meeting the standard as it includes the prevention of secondary illness giving the opportunity for longer life expectancy. The operational benefits are identified and as are the cost benefits.
Corrective Action:
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: The activities coordinator has completed her national certificate in care of the elderly up to the level of advanced dementia care and is commencing diversional training this year. Minutes are seen of the residents' meetings held every month and follow up of any issues. The activity plan includes housie, exercises and school visits. A contracted

diversion therapist is working with the activity coordinator to assist with programme planning and implementing games that are suitable for the residents in this facility.

The two residents and five relatives report they enjoy the activities provided and are consulted during one to one on any other requirements. Documentation is all up to date and reviewed.

ARRC requirements are met.

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

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

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:

Policy requires that an evaluation is undertaken to measure the degree of achievement or response of each resident related to their goals six monthly. In all six of the six files reviewed evidence is seen of the resident's desired outcomes being implemented in the care plans.
When a resident has progress different from expected or an adverse event, evidence of this recorded in the short term care plan. Any changes to resident conditions are provided to staff at handover and also include any relevant education if required. Evidence is seen in the resident's file of a resident on a short-term care plan. This was noted in three files reviewed as is appropriate (the other three files had nothing that required a short term plan). This can relate for example, to challenging behaviour, urine and chest infections. If an on-going risk or problem is identified this is then transferred to the long-term care plan. The clinical manager reports an example of a resident with a urine infection; the resident was put on bed rest, given extra fluids and the GP visited and prescribed antibiotics.

ARRC requirements are met

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

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

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:
Residents admitted to Orewa Secure Care are given the choice of retaining their own GP or using the GP contracted to the facility. The facility has one GP who is

contracted. A GP was available for interview during the audit and has no concerns relating to the care at Orewa Secure Care. The two residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. The clinical manager reports that residents are given the choice of changing facilities if they are not happy and also if their health needs change.

ARRC requirements are met

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Stage one: These safe medicine management guidelines outline the most suitable procedures for ensuring the safety and efficacy of medicine use. Describe minimum standards for storage and use of medicines. Blister pack system is used at the facility. Policy states all medication is administered by the registered nurse or caregivers who have been competency tested. The policies and protocols cover all aspects of medicine management that complies with current legislative requirement and safe practice guidelines. This includes resident self-administration of medicines and standing orders. A medication management policy is documented and refers to the processes to be used to prescribe, dispense, administer, review, store, dispose of medications. Resident's allergies are established during admission assessment and documented in the medication administration chart. Staff must always check any medication allergies. Any allergies or sensitivities are clearly noted on the medication administration chart. If no allergies are known then this is documented to identify that it has been checked. The standing orders are up to date and comply with legislative requirements. The policy details how medications are to be stored and includes in the original dispensed packs. Medications are to be stored securely away from moisture and lights (or in a refrigerator if appropriate). There are controlled drugs on the premises kept in a locked cupboard accessible when required. A Controlled Drug Register is available and controlled medications processes are up to date. The blister packs are delivered monthly or earlier if required and each are checked to ensure they are correct with the medication sheet. The process for reporting medication errors or omissions is detailed within the policy. The process for identifying residents and administering medications is detailed along with documentation responsibilities. The process for documenting standing orders is detailed. If a resident chooses to self-medicate and has been doing so at home they may do so if assessment (a template is provided) shows that they are capable to do this. The

CM assesses a resident's ability to take their own medication with the GP at least every 3 months or when their physical or cognitive state changes. Self-administration of medication must be noted on the resident's care plan. There are no residents self-medicating on the day of the audit and all requirements are met. Controlled medicine is not self-administered.

There are staff competency assessment processes for oral and other medications, insulin, other injections and warfarin. The qualified caregivers responsible for medicine management have an annual competency review prior to administering medicines. The caregiver was observed during the lunchtime medicines round and correct procedures are followed. Completed assessment forms are seen of caregivers competent to give medication on the day of audit. The two residents and five relatives spoken with, report the GP discusses their medicine requirements. All twelve medication sheets reviewed contain all aspects of the requirements of the medication management policy.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: There is a food services manual which describes all safe food processes.

Orewa Secure Care operates a four week menu. An individual dietary assessment is completed on admission which identifies individual needs and preferences. Evidence is seen of dietitian review of menu every two years. This is carried out in consultation with the family/whanau as required. Morning and afternoon teas are prepared in the kitchen and there are sandwiches available over 24 hours. The care planning policy identifies that the food, fluid and nutritional needs of the resident will be provided in line with recognised nutritional guidelines that are appropriate to the consumer group.

The kitchen staff attend a course for safe food handling every two years evidence seen in staff files.

In six of the six residents' files reviewed, there is evidence of initial dietary assessment identifying specific needs and the kitchen is notified accordingly. This can include vegetarian diets, diabetic diets or cultural requirements.

The lunch time meal was observed on both days of the audit and residents spoken to are happy with the meals provided. Policy identifies that additional or modified nutritional requirements or special diets are part of the care planning process. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

The cook reports that she is always made aware by the CM of any specific dietary requirements for residents. Residents' personal preferences are identified on admission in consultation with the family/whanau. Likes and dislikes are discussed with the staff and as the facility is small, staff are able to identify if the meals are meeting the residents' choices. There are lists on the fridge in the kitchen which identifies special dietary needs, likes and dislikes.

The cook and kitchen hand report on interview that they listen to the needs of residents. Up to date cleaning schedule and temperature recordings are sighted. ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: Stage one: Policy states that all chemicals potentially hazardous to health are stored securely in order to minimise the risk of accidental exposure or ingestion by residents, staff or visitors to the facility. Policies and procedures identify that waste and sharps are appropriately disposed of. Stage two: The above policies and procedures are implemented as observed at the onsite audit. The chemicals are observed to be securely stored in the laundry, cleaners' cupboard and sluice rooms. The laundering of the linen is conducted off-site by a contracted agency, with the personal clothing done on sight as part of the caregivers duties. There are specific cleaning staff. The staff who participates in the laundry and cleaning report that they follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation. There is appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The laundry worker/cleaner interviewed report that they have had training in the handling of waste or hazardous substances, which is conducted by the external chemical provider and as part of the ongoing in-service education programme, last conducted March 2014 (all care staff who participate in the laundry service completed the training). The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The building warrant of fitness expires April 2015. Equipment is maintained to ensure safety. Electrical tag and testing was last conducted in September 2013 and is routinely conducted on a 2 year cycle. The calibration of the medical equipment is last conducted in April 2014 (includes hoist, scales, nebuliser, electric beds, sphygmomanometers, thermometer). The facility is demonstrating generalised wear and tear that is reflective and acceptable for the age of the building. The service has a planned and reactionary maintenance programme, with the building maintained in an adequate condition to meet the needs of the residents. The maintenance log notes area of work required and is signed off when the work is completed. The fittings and furniture installed are maintained to ensure safety and the needs of the residents. The furniture cleaning is part of the planned maintenance and cleaning programme. The physical environment is appropriate for the residents. Hand rails are installed in corridors. There is disability access at all entrances. The residents' rooms sighted are personalised with the resident's possessions. Residents are provided with safe and accessible external areas that meet their needs. There are disability access ramps of the veranda in the dementia unit. There is a pathway in the dementia unit that has a loose shell surface; residents are observed to the mobilising freely in this area and the owner reports that there have been no incidents or falls in the area. The service also has a veranda that is accessible off most of the resident's rooms and lounge areas in the rest home/hospital section. The areas for secure specialist dementia care are separated from the rest home and hospital sections of the service. Hot water temperatures in resident areas are monitored monthly. The temperatures sighted are within the safe temperature guidelines for aged care.

The ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

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

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)
Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: There are adequate numbers of accessible toilets/showers/bathing facilities, conveniently located and in close proximity to each service area to meet the needs of the residents. There are three showers in the rest home/hospital sections and 14 toilets. The dementia unit has three showers and nine toilets. The toilets and showers are clearly identified with signage. The toilets have engaged/vacant privacy locks. The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines. The bathrooms are large enough to accommodate a shower/bath trolley. The facilities for the residents living in the secure dementia unit are separated from the rest home/hospital sections of the service. The two of two residents and five of five family/whanau report satisfaction with the toilets and shower facilities. The ARRC requirements are met.

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: The service has one room that is currently used for a married couple and all other rooms are single occupancy. All rooms sighted are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. All the rooms in the dementia unit are single occupancy. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents can freely move around the facility. The two of two residents and five of five family/whanau interviewed report satisfaction with their rooms and all state that they really appreciate the large size and outlook of the rooms. The ARRC requirements are met.

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 are lounge and dining areas throughout the facility in both the rest home/hospital and secure dementia unit. There are two lounge areas in the rest home/hospital section and a separate dining room. The rest home/hospital sections have a separate family/whanau room for smaller groups. The lounge and dining areas are separated and activities in these areas do not impact on each other. The resident rooms also have facilities for family/whanau if the resident wishes to entertain in their room. Most rooms have direct access through ranch sliding doors to a veranda. The specialist dementia service facilities are separated from the rest home/ hospital section, with a lounge and dining area in the dementia unit. The two of two residents and five of five family/whanau interviewed report satisfaction with the lounge and dining facilities.

The ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Cleaning and laundry services policies and procedures sighted.

Stage two: The laundering of the linen is conducted offsite by a contracted company, with the care staff assisting with the washing of the residents' personal clothing. The cleaning is conducted onsite by designated domestic staff. The laundry has a dirty to clean flow. The external chemical supplier conducts a monthly surveillance of the cleaning and laundry processes and sends this report to the services head office. The cleaning and caregivers interviewed who assist with laundry services report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. The resident and relative satisfaction survey conducted in 2013 records that 98% of the respondents are satisfied to very satisfied with the laundry and 95% are very satisfied to satisfied with the cleaning of the facility. The two of two residents and five of five family/whanau interviewed report satisfaction with the cleaning and laundry services.

The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has adequate emergency supplies in the event of an emergency or outbreak. The cook reports there is a least two weeks supply of food at all times. The service has stores of drinking and non-drinking water for emergency use. There is a civil defence kit with additional food, first aid and emergency supplies. In the case of mains failure the service has access to emergency lighting and gas cylinders supply heating and cooking. The service has access to alternative gas supply and a generator if required for an emergency situation.

All resident rooms, bathrooms and lounge areas have a call bell system installed. The call bell system has an audible alert, a light that comes on above the door if the call bell is activated and panels in the corridors. The call bell system is monitored for response times, with no ongoing issues indicated for the timely response to call bells. The two of two residents and five of five family/whanau report that the call bell is answered in a timely manner.

The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The three of three caregivers interviewed demonstrate knowledge on responding to emergency situations. The registered nurses have current first aid qualifications (last updated in February 2014) and there is at least one staff member on duty at all times that has the current qualification.

The approved evacuation plan is dated 23 January 2014. There have been no changes to the layout of the service that have required changes to the approved evacuation scheme. The service conducts six monthly evacuation training, with the last drill conducted May 2014. The service then conducts a fire and safety questionnaire for staff to complete.

The service identifies and implements appropriate security arrangements relevant to the residents at rest home/hospital level of care. The service has a secure dementia unit that is separated from the rest home/hospital section. The afternoon staff are required to close and lock the external windows and doors before it gets dark and a security gate in the front driveway that has automated access in the day time and access through an intercom system after hours. The service has external security lighting. There are internal security cameras in the corridors and entrances of the service. The five of five caregivers interviewed report that they feel safe and secure when working afternoon and night shifts. The two of two residents and five of five family/whanau interviewed report they feel safe and secure at night.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)
Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence:
Areas used by residents and staff are ventilated and heated appropriately. The service has a combination of wall panelled heating and heat pumps to provide heating in resident areas. All resident-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light and ventilation. The

two of two residents and five of five family/whanau report satisfaction with the natural light, ventilation and heating.

The ARC requirements are met.

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Stage one: Policy indicates the service is committed to providing a restraint free environment. There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety. Stage two: There are no current residents that have enabler use. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety (as confirmed in the assessment process sighted). The five of five caregivers interviewed demonstrate understanding that enabler use is voluntary and the least restrictive option. There is no restraint or enabler use in the dementia unit. The service demonstrates that the use of restraint is actively minimised. The restraint register records that there are three residents with restraint use. This has reduced from five residents with restraint use at the start of 2014. The service reviewed the use of the restraint for these residents and have been able to safely remove the use of the restraint (bed rails) after a training period. This did not result in increased falls for the residents. The ARRC requirements are met.

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

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

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA
Evidence: The service currently has three residents assessed as requiring restraint (bed rails or safety belt), these are used for safety of the resident. All three of these files are reviewed for the restraint criteria. The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. The clinical manager is the restraint coordinator. All of the three files reviewed of residents with restraint use have a documented restraint approval process that reflects the organisations policies and procedures for the implementation of the restraint. There is a pre assessment that is conducted by the RN. When it is indicated that restraint use is required from the pre –assessment, final approval is gained by the restraint coordinator, GP and family prior to the use of restraint. When restraint is approved, there is a consent that is signed by the enduring power of attorney (EPOA), RN and GP (confirmed in the three files reviewed). The three of three care plans sighted for the residents with restraint use record that the focus of the use of the restraint is to prevent injury as a result of falls. The bed rails and lap belts are used minimally and only as indicated (eg, if the resident is settled and not prone to fall from the chair the lap belt is not used). The ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The restraint coordinator (clinical manager) reports that restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by identification of triggers, health problems, medications, physical, social or environmental issues. Assessment also considers risk and benefits of restraint or enabler use, such as, will it compromise the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm, and is there a balance between independence and protection. The restraint coordinator reports that if the resident is at more risk of injury through the implementation of restraint, then restraint would not be used (eg, if potentially more at harm from climbing over bed rail or becoming anxious and agitated with lap belt or bed rail use). The three files reviewed of residents assessed as requiring restraint identifies that assessments were undertaken for the appropriate and safe use of the restraint devise. Assessments are completed by the restraint coordinator or RN. All restraint assessments are updated at least three monthly and all restraints are reviewed at least three monthly through a restraint audit and evaluation. The restraint use is also discussed and reviewed at the monthly staff meetings. The five of five caregivers interviewed have an understanding and implement alternatives to restraint, such as low beds, and behaviour management whenever possible. The ARRC requirement is met.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

The restraint coordinator (clinical manager) reports that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained. At the time of audit, bed side rails and lap belts are the approved restraints. Restraint planning and application of restraint is undertaken only if the assessment process indicates the use of restraint would be appropriate. Frequent falls by individual residents will often generate commencement of assessment processes and all alternative methods of keeping the resident safe are identified. The restraint monitoring form records when the restraint is applied, the checks of the resident and when restraint is removed. The monitoring form records the observations and interventions whilst the resident is in the restraint. Restraint is documented in the resident's file and in the restraint register (sighted). The register records the resident's name, type of restraint, when commenced and date discontinued. All restraint is consented to by the family/whanau.

The ARRC requirement is met.

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

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA
Evidence: The restraint coordinator reports that all restraint use is evaluated at least three monthly as part of the resident review process. The restraint use is also reviewed at the monthly staff meetings. The three of three residents' files reviewed document the three monthly evaluations. The organisational evaluation process for restraint use includes family/whanau and resident input as appropriate. The template for the review and evaluation of restraint includes all the points of the standard. Restraint reviews are reported and discussed at the staff meetings and types of restraints in use are monitored by the restraint coordinator. The care plan of the all residents with restraint use is congruent with assessment findings. The ARRC requirement is met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The restraint monitoring form for the resident reviewed with restraint use records 30 minutes to two hourly checks to ensure the safety and rights of the resident are not compromised. The restraint monitoring forms are used for residents assessed as high risk (eg, 30 minute checks) for restless residents. The monitoring form records measures taken to minimise the effects of restraint. The observation records interventions, such as, walks, pressure area care, change of environment, personal care, foods and fluids given or recreational therapy. The monitoring form records the staff observations on comfort, psychological and physical effects. The monitoring forms of the three residents assessed reflect the assessed needs of the resident, and are often recorded more frequently than the minimum requirements. The service conducts a three monthly review and evaluation of the restraint use. This includes all points of the standard. The quality review and evaluation of all three residents assessed as requiring restraint use occurred March 2014 and is next due for formal evaluation in June 2014.

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

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

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

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

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

ARC D5.4e ARHSS D5.4e

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

precautions.

ARRC requirements are met.

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: Stage one: Policy states that every infection is reported on an infection report form; this information is collated monthly and reviewed and analysed by the infection control coordinator who will advise management of the outcome. The Infection Control coordinator has access to adequate resources to enable then to achieve their responsibilities. In the case of an outbreak, advice will be sought from the GP, laboratory services and experts at the WDHB. The IPCC/RN is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation. Education is also provided by the nurse specialist at WDHB and staff are given the opportunity to attend these in-service education sessions. The nine staff interviewed report good knowledge of infection control, standard precautions and outbreak management. The two residents and five families are informed of any infections and notices are put on the door when required. ARRC requirements are met.

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: Stage one: There is a full suite of policies and procedures that reflect current accepted good practice and meet relevant legislative requirements. The policies could be strengthening by referencing or linkage to current accepted good practice. The nine staff (three RNs, two caregivers, one activity coordinator, one cleaner, one laundry and one cook) report they are informed of any policy changes as part of the education programme. They are also given the opportunity to attend WDHB in-service education on infection control. The RN/IPCC attends workshops as provided by the WDHB. ARRC requirements are met.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)
There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)
The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: Hospital, Rest Home and Dementia: Staff orientation covers infection control education relevant to practice within the organisation. Infection prevention and control education was provided to all staff in 2013 and 2014 (evidence sighted). The nine staff interviewed confirm attending this in-service education. The education plan for 2014 is sighted and includes infection control sessions. Education is provided to residents (and/or family members) related to hand hygiene and isolation, if there is an infection outbreak. This is confirmed in interview with residents and families members. ARRC requirements are met.

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:
Stage one: The infection control co-ordinator has access to infection control information collected within the organisation and has sufficient resources and systems to collect the necessary information. All infections are recorded on infection report forms, collated once a month, analysed and action taken when required. Outcomes taken to staff meeting and any necessary corrective actions discussed. The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy. Policy states that surveillance will be presented at staff meetings. An annual summary of the number and type of infections per month is maintained and sighted for 2013. A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes

whether further follow-up is required. The data is imputed into the computer each month and reports surveillance data at monthly staff meetings.

Evidence is sighted of surveillance data from the initial completion of the infection notification form and the process around how this becomes part of the quality system. Staff report they are notified of any infections at handover and families are contacted.

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

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

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

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

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

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