# Rotorua Continuing Care Trust

## Current Status: 15 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

Whare Aroha Home and Hospital is run by the Rotorua Continuing Care Trust. This certification audit was undertaken to establish compliance with the health and disability services standards and the district health board contract. Whare Aroha Home and Hospital provides rest home, hospital and specialised dementia care for up to 78 residents. Occupancy on the day of audit was 73. There have been no major changes to buildings, management, plant and equipment since the last audit.

Evidence gathered indicates the residents are treated with respect and dignity and have their rights upheld. An expected level of care and support was being provided with three low risk areas for improvement being identified. These related to general practitioner prescribing practice, provision of restraint/enabler training and ensuring care plans in the dementia suite are sufficient to manage behaviours over a 24 hour period.

## Audit Summary as at 15 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 15 May 2014

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

### Organisational Management as at 15 May 2014

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

### Continuum of Service Delivery as at 15 May 2014

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

### Safe and Appropriate Environment as at 15 May 2014

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

### Restraint Minimisation and Safe Practice as at 15 May 2014

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

### Infection Prevention and Control as at 15 May 2014

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

## Audit Results as at 15 May 2014

### Consumer Rights

Whare Aroha Home and Hospital provides appropriate and accurate information about their services. Appropriate discussion is held with the resident and family/whanau on admission to explain and discuss all information given. The organisation is committed to open disclosure principles. Cultural and individual values and beliefs are identified on admission. Staff receive education to ensure services are delivered in a manner that recognises and meets the values, needs, and wishes of each resident. The informed consent information is provided and processes are followed. Residents and family interviewed confirm that they are fully informed about all aspects of service delivery.

There is an appropriate complaints process and the complaints register is maintained by the general manager. Advocacy and support services are available as required. The service is able to demonstrate appropriate interactions with family/whanau and community services. The Health and Disability Services Consumers` Rights (the Code) is clearly displayed in all service areas and pamphlets are readily accessible. Staff have received education on the Code and this is ongoing.

### Organisational Management

Whare Aroha Home and Hospital is a charitable trust and governed by a board of directors. The purpose, values, scope, direction and goals of the organisation are displayed and reflected the services provided. Day to day operations are the responsibility of the general manager who has appropriate skills and experience.

The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. A number of quality improvement initiatives have been implemented. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and monitored.

Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. Orientation/induction and training is in place, however training on restraint/enablers needs to be included into the training programme in a more consistent manner. Staff performance is monitored through annual performance appraisals.

Resident records are secure and well maintained.

### Continuum of Service Delivery

The residents’ records provide evidence that all residents have been assessed appropriately prior to admission. The service has well implemented systems to assess, plan and evaluate care needs of the residents. The resident`s needs, outcomes and/or goals have been identified and these are reviewed on a regular basis with family input. A team approach to care and delivery and continuity of service delivery is encouraged.

Medication management is safely implemented and a visual inspection of the medication systems and the lunchtime medication round evidences nursing staff comply with respective legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing medication three monthly or more often if required. There is one area of requiring improvement in relation to a general practitioner grouping the prescribed medications and signing with one signature not each medication individually.

Food services policies and procedures are appropriate for the service setting. The service is managed by an experienced cook. The menu plans have been reviewed by a dietitian. The menus are documented and displayed daily. The individual dietary needs during the assessment process for each resident on admission are addressed and choices provided. Meals are provided at appropriate times of the day.

The activities programme and the Eden Alternative ten principles are well implemented and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are meaningful and the programme is developed and implemented to ensure interests of residents are included. Outings in the community are arranged and entertainers come into the service on a regular basis.

### Safe and Appropriate Environment

The facility is appropriate to the needs of the residents and fit for purpose. The building is separated into three areas which include the rest home, hospital and secure dementia suite. The building, facilities, furnishings and equipment are well maintained and suitable for the care and support of the residents. Applicable building regulations and fire safety requirements are met.

Well-furnished lounges, dining areas and safe external areas are accessible to all residents. The facility has plenty of natural light and is maintained at a comfortable temperature. All bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. Additional thought has gone into ensuring the dementia suite supports a safe and stimulating environment for the residents in line with the Eden philosophy.

Toilet, shower and bathing facilities are sufficient in numbers and adequately equipped and furnished. The temperature of hot water is monitored to ensure resident safety.

Laundry and cleaning services are sufficient and monitored for effectiveness. Both meet safety and infection control requirements. The collection, storage and disposal of waste is in accord with local body requirements.

Processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The call system is working effectively and there are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

### Restraint Minimisation and Safe Practice

The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. The policy clearly defines restraint and enabler use. Only enablers are used presently and the restraint register sighted is current and up to date. Staff are educated about the service policy. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Safety is promoted at all times.

### Infection Prevention and Control

The infection control programme is clearly documented and is suitable for the facility. The infection control programme is reviewed on an annual basis. The nurse coordinator is responsible for the facilitation and implementation of the infection control programme and staff are aware of their responsibilities, including reporting residents suspected of having an infection.

Infection prevention and control policies and procedures are sufficient and aligned with current accepted practice. Staff interviewed confirm access to the required procedures and resources. Training on infection prevention and control is provided in an ongoing manner.

Infection control surveillance is occurring for residents who develop infections. The surveillance programme is appropriate to the service setting. Any trends are communicated at staff meetings, management and board reports. The use of antibiotics is monitored to ensure appropriateness.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Rotorua Continuing Care Trust |
| **Certificate name:** | Rotorua Continuing Care Trust |

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| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

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| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Whare Aroha Home & Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care | | | |
| **Dates of audit:** | **Start date:** | 15 May 2014 | **End date:** | 16 May 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 73 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 12 |
| **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** | 3.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 23.5 | Total audit hours | 55.5 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 10 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 10 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 22 | Total number of staff (headcount) | 81 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Friday, 30 May 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Whare Aroha Home and Hospital is run by the Rotorua Continuing Care Trust. This certification audit was undertaken to establish compliance with the health and disability services standards and the district health board contract. Whare Aroha Home and Hospital provides rest home, hospital and specialised dementia care for up to 78 residents. Occupancy on the day of audit was 73. This included 21 residents receiving rest home level care, 21 residents in the secure dementia suite and 31 residents receiving hospital level care (six of whom are under the age of 65 and require residential disability care). There have been no major changes to buildings, management, plant and equipment since the last audit.   Evidence gathered indicates the residents are treated with respect and dignity and have their rights upheld. An expected level of care and support was being provided with three low risk areas for improvement being identified. These related to general practitioner prescribing practice, provision of restraint/enabler training and ensuring care plans in the dementia suite are sufficient to manage behaviours of concern over a 24 hour period. |

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| **Outcome 1.1: Consumer Rights** |
| Whare Aroha Home and Hospital provides appropriate and accurate information about their services. Appropriate discussion is held with the resident and family/whanau on admission to explain and discuss all information given. The organisation is committed to open disclosure principles. Cultural and individual values and beliefs are identified on admission. Staff receive education to ensure services are delivered in a manner that recognises and meets the values, needs, and wishes of each resident. The informed consent information is provided and processes are followed. Residents and family interviewed confirm that they are fully informed about all aspects of service delivery.   There is an appropriate complaints process and the complaints register is maintained by the general manager. Advocacy and support services are available as required. The service is able to demonstrate appropriate interactions with family/whanau and community services. The Health and Disability Services Consumers` Rights (the Code) is clearly displayed in all service areas and pamphlets are readily accessible. Staff have received education on the Code and this is ongoing. |

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| **Outcome 1.2: Organisational Management** |
| Whare Aroha Home and Hospital is a charitable trust and governed by a board of directors. The purpose, values, scope, direction and goals of the organisation are displayed and reflected the services provided. Day to day operations are the responsibility of the general manager who has appropriate skills and experience.    The organisation has a quality and risk management system that is monitored and reviewed to generate improvements in practice. A number of quality improvement initiatives have been implemented. The required policies, procedures and work instructions are in place and accessible. Goals for quality are defined and achievement towards these are reported and communicated. The organisation also implements an internal monitoring programme and corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is well documented and monitored.  Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. Orientation/induction and training is in place, however training on restraint/enablers needs to be included into the training programme in a more consistent manner. Staff performance is monitored through annual performance appraisals.  Resident records are secure and well maintained. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The residents’ records provide evidence that all residents have been assessed appropriately prior to admission. The service has well implemented systems to assess, plan and evaluate care needs of the residents. The resident`s needs, outcomes and/or goals have been identified and these are reviewed on a regular basis with family input. A team approach to care and delivery and continuity of service delivery is encouraged.  Medication management is safely implemented and a visual inspection of the medication systems and the lunchtime medication round evidences nursing staff comply with respective legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing medication three monthly or more often if required. There is one area of requiring improvement in relation to a general practitioner grouping the prescribed medications and signing with one signature not each medication individually.  Food services policies and procedures are appropriate for the service setting. The service is managed by an experienced cook. The menu plans have been reviewed by a dietitian. The menus are documented and displayed daily. The individual dietary needs during the assessment process for each resident on admission are addressed and choices provided. Meals are provided at appropriate times of the day.  The activities programme and the Eden Alternative ten principles are well implemented and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are meaningful and the programme is developed and implemented to ensure interests of residents are included. Outings in the community are arranged and entertainers come into the service on a regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility is appropriate to the needs of the residents and fit for purpose. The building is seperated into three areas which include the rest home, hospital and secure dementia suite. The building, facilities, furnishings and equipment are well maintained and suitable for the care and support of the residents. Applicable building regulations and fire saftey requirements are met.   Well-furnished lounges, dining areas and safe external areas are accessible to all residents. The facility has plenty of natural light and is maintained at a comfortable temperature. All bedrooms are of sufficient size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. Additional thought has gone into ensuring the dementia suite supports a safe and stimulating environment for the residents in line with the Eden philosophy.  Toilet, shower and bathing facilities are sufficient in numbers and adequately equipped and furnished. The temperature of hot water is monitored to ensure resident safety.  Laundry and cleaning services are sufficient and monitored for effectiveness. Both meet safety and infection control requirements. The collection, storage and disposal of waste is in accord with local body requirements.   Processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The call system is working effectively and there are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. The policy clearly defines restraint and enabler use. Only enablers are used presently and the restraint register sighted is current and up to date. Staff are educated about the service policy. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Safety is promoted at all times. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme is clearly documented and is suitable for the facility. The infection control programme is reviewed on an annual basis. The nurse coordinator is responsible for the facilitation and implementation of the infection control programme and staff are aware of their responsibilities, including reporting residents suspected of having an infection.   Infection prevention and control policies and procedures are sufficient and aligned with current accepted practice. Staff interviewed confirm access to the required procedures and resources. Training on infection prevention and control is provided in an ongoing manner.  Infection control surveillance is occurring for residents who develop infections. The surveillance programme is appropriate to the service setting. Any trends are communicated at staff meetings, management and board reports. The use of antibiotics is monitored to ensure appropriateness. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 42 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 3 | 0 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Restraint and enabler training is not provided during orientation and there is insufficient evidence that related training is being conducted in an ongoing manner.   Post Audit: The Provider does not agree with this finding. | Provide training on restraint/enablers in an ongoing manner. | 180 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is no mention in the resident support plans for the dementia level residents of the current abilities, level of independence, deficits and as far as practicable their personal preferences, individual habits, routines and idiosyncrasies.  Post Audit: The provider does not agree with this finding. | To identify and ensure the resident needs are clearly identified and describe appropriate support and/or intervention to achieve the goals identified by the ongoing assessment process. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | On review of the medication records it was observed that one general practitioner is bracketing the prescribed medications and signing off all medications with the one signature. | To ensure each prescribed medication is signed off individually on the medication record by the general practitioner. | 180 |

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

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

## **Outcome 1.1: Consumer Rights**

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

#### Standard 1.1.1: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Clinical and non-clinical staff interviewed all demonstrate knowledge and understanding of resident rights, obligations and how to incorporate them as part of their everyday practice. As observed at the onsite audit staff are seen addressing residents with respect, knocking on doors and asking to enter rooms prior to entering and providing residents with choices. Maintaining privacy and confidentiality is also understood clearly by staff interviewed.  The district health board contract 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy is in place to guide staff actions to ensure residents` rights are discussed and available to residents and family/whanau. The Code of Health and Disability Services Consumers` Rights (the Code) is clearly displayed throughout all areas of service delivery in the reception, Manaaki Suite (rest home), Wairua Suite (hospital) and Manaia Suite (dementia care). The two of two family members interviewed separately report they are provided with information on the Code on admission, the information is in the admission pack sighted, information brochure and the service agreement. The administration staff, the clinical manager and/or the registered nurses provide information on the Code. The Code is available in both Maori and English versions. The Code is also available from the office of the Health and Disability Commissioner in a variety of languages if and when required. The Nationwide Health and Disability Advocacy Service poster is displayed and information is accessible. The contact numbers are on the reverse of the Health and Disability Services Consumers` Rights brochure.  The district health board contract 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.

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

##### **Criterion 1.1.2.4 (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.

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

#### Standard 1.1.3: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Privacy policy identifies the organisation respects the privacy of all residents at all times. The general manager is the privacy officer for this organisation. The 10 of 10 residents (five rest home and five hospital) and two of two family interviewed separately express a high level of satisfaction with the way they are treated by all staff (health care assistants, allied health, medical, housekeeping, rehabilitation therapist, laundry, maintenance and kitchen staff) and report that the resident`s dignity, privacy and independence is promoted at all times and respected. The general practitioner (GP) interviewed express no concerns with abuse, neglect or culturally unsafe practice. There is an abuse and neglect policy reviewed May 2012 available to guide staff. Nursing and care staff interviewed (the nursing co-ordinator, one registered nurse, three health care assistants) understand how to report such incidences if suspected or observed. The education plan for 2014 was sighted.  Information on the Nationwide Health and Disability Advocacy Services is provided in the admission information, with the poster and the Code brochures being readily available. The advocacy contact details for the region are available from reception. The rooms in all services sighted are individual, personalised and privacy is not compromised. Resident`s own property is recorded on admission and a copy is flied in the individual records reviewed. There are two double rooms in the facility and both of these are in Manaia Suite (dementia care). One is shared by a couple and the other by two friends/family members and this arrangement was consented by families. Staff interviewed state that they ensure residents are well managed in Manaia Suite from entering other resident`s rooms as much as possible as the doors are left open in all rooms.  Information record sheets are completed on admission to all services and the needs, values and beliefs inclusive of cultural, religious, social and/or ethnicity is identified for each individual resident. The residents preferred name is also ascertained on admission and documented and used by staff when addressing residents or family/whanau members. Local ministers visit twice weekly or can be accessed as required for resident/family/whanau. An Anglican Chaplin provides communion and/or the Catholic Priest on a regular basis. The Kaumatua Chaplain holds a church service every Tuesday and provides individual visits to residents unable to attend the arranged service.   The district health board contract 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.

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

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

##### **Criterion 1.1.3.6 (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.

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

##### **Criterion 1.1.3.7 (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.

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

#### Standard 1.1.4: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy states that the services will ensure that the cultural values and beliefs of residents, their whanau and staff are respected, recognising the Treaty of Waitangi in the day to day practices. Currently there are 21 residents of 73 who identify as Maori (40%) and 29 Maori staff are employed across all services. There has always been Maori representation of the Board of Trustees for this organisation. The facility is positioned on land of Ngati Whakaue. There is a Kaumatua and a Kuia available for this service. The Kuia is available to bless rooms as required. Staff interviewed clinical (the nursing co-ordinator, one registered nurse and three health care assistants) and non-clinical ( the cook, laundry staff, two activities co-ordinators, one administrator and one associate administrator) are fully informed on Tikanga practices and ensure at all times that these are adhered to. Staff of all nationalities are represented and are mindful of meeting the needs of all Maori residents. Nutritional needs such as `boil ups` are enjoyed by the Maori residents and others on a regular basis as confirmed at resident and family interviews. Extended family/whanau are welcome anytime to join in the activities programme in any of the three service areas.  The service promotes equal access to services for Maori residents. The Maori health model adopted by the organisation recognises the importance of understanding and recognising Maori beliefs and values and the significance to Maori. There is acknowledgement that Maori have special beliefs, skills and knowledge about health inclusive of: Taha hinegaro – mental wellbeing, Taha tinana - physical wellbeing, Taha Wairau – spiritual wellbeing and Taha whanau – family wellbeing. The spiritual, emotional and cultural section in the care plans is combined with and reflects the Eden philosophy adopted by this organisation. An Eden meeting is held fortnightly. The client support manager and other staff are able to speak fluent te Reo.  The district health board contract 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.

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

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

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

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

##### **Criterion 1.1.4.5 (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.

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

#### Standard 1.1.6: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Whare Aroha Rest Home and Hospital policy recognises that every individual is inherently influenced by the cultural environment with which they relate and that influence remains with the individual despite a change in living environment. The clinical manager and staff interviewed ensure all cultures, values and beliefs of residents are recognised and that everyone is treated as an individual and provided the support required to practice the beliefs that they have identified as important to them. Cultural values and beliefs are actively recognised and integrated into the daily life of the resident by reflecting this in the long term care plans and providing the support and interventions necessary to maintain relationships between residents, their families/whanau and the community. Information is obtained by the registered nurses in the initial assessment on admission for all individual residents. Any identified values and beliefs are clearly documented and this is evidenced on the 10 of 10 resident files reviewed. The Kaumatua and/or the Kuia can be contacted if needed.  The district health board contract 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.

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

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

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

ARHSS D16.5e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a policy on discrimination and this is also referenced in the abuse of residents policy reviewed. Policy also sighted states that intimacy and sexuality are managed in a manner that ensures that the rights of the individual are protected and intervention occurs to ensure balance between personal rights of the individual and others living and working in the facility for example the dementia care service. The clinical manager, registered and enrolled nurses interviewed are fully informed and aware of professional boundaries. All registered staff have to complete a Professional Boundaries Workshop over the next year to meet the New Zealand Nursing Council requirements for scope of practice requirements. The organisation has house rules and staff interviewed (clinical and non-clinical) abide by these rules as part of the employment agreement and human resources management protocol. |

##### **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.

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

#### Standard 1.1.8: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service is fully committed to the Eden Alternative philosophy and this is becoming embedded into and across all services. The Eden Alternative 10 principals are clearly displayed in the lift and the tree of life is clearly visible in the Wairua and Manaaki Suites. Residents find their names on the tree of life. Policies and procedures are up to date and the care plans are updated as per the schedule by the registered nurses. Any care plans updated by an enrolled nurse are verified and signed off by a registered nurse or the clinical manager. The care plans are currently being updated to new excel model as per the `Project Scope`. Feedback is encouraged from families/whanau, allied health personal and staff. Other quality initiatives include the development and implementation of advanced care plans. These are being driven in this region by the Royal College of General Practitioners and copies and pamphlets are available at reception and in the rest home and hospital services. The GP interviewed reports these are being put in place and encouraged for residents receiving services.  The 3 pm daily staff handovers are working well with information sharing. Good communication was observed during this process. The incident/accident system is documented electronically with a new system being utilised which identifies any trends and /or actions to be undertaken with immediate response. The quality improvement team has just evaluated a recent resident satisfaction survey and the numbers received back from residents has increased from thirty percent (30%) to thirty nine percent (39%) which has been positive for the team. The surveys evidence that more families/whanau are actively involved with the services and residents care. This was observed and commented on during a family interview in Manaia Suite. Other family were actively participating with the residents in activities. The GP commented that communication has improved remarkably with the senior registered nurses and the appointment of the clinical manager.  The district health board contract 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures identify and have a common theme which includes all residents` rights to full and frank information as per the open disclosure policy. The policies are available to guide staff. Staff interviewed, the clinical manager, a registered nurse, an enrolled nurse and the contracted GP are fully aware of open disclosure and providing accurate and appropriate information. Interpreter services are available through Lakes District Health Board Rotorua Hospital, if required. Staff employed represent different nationalities such as Tongan, Samoan, German and Indian. Staff Interviewed comment they could translate/interpret if required and appropriate. Several staff can speak fluent Maori te Reo inclusive of the Kaumatua and the client support service manager. Staff wear name badges with their first name only and this was decided upon by the staff themselves.  The district health board contract requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### Standard 1.1.10: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The services have specific advanced directive documentation which identifies resident and GP involvement in this process. This includes advanced directives related to residents` resuscitation wishes. The advanced directives are reviewed during the six monthly multidisciplinary reviews or earlier if required. Policy sighted relates to informed choice and consent and this information is compliant with the Code requirements. Copies of consent forms sighted includes receiving and recording information, providing relevant or seeking relevant information, enrolling in the GP practice primary health organisation , administration of the influenza vaccination, training, outings and activities and lastly photography.  The district health board contract 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.

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

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

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

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

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

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

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

#### Standard 1.1.11: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy identifies that advocacy services are an essential provision allowing residents appropriate access to independent advice and support in accordance with the cultural responsiveness policies, with all residents receiving services which have prompt access if required to a culturally and spiritually appropriate advocate. Advocacy information is made available for residents (and potential residents) and is clearly displayed throughout the reception, Manaaki, Manaia and Wairua Suites. The regional Advocacy Service contact numbers are documented on the reverse of the Code brochure sighted. Residents can have support persons of their choice who are able to visit and stay most of the day. The education plan for 2014 was sighted.  The district health board contract 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.

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

#### Standard 1.1.12: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are no set visiting hours and family/whanau are encouraged to visit. The two of two family interviewed confirm unrestricted visiting hours and this is appreciated. Residents are supported and encouraged to access community services independently if possible with visitors or as part of the planned activities programme such as aged concern, returned service association (RSA), Stroke Club and Man`s Shed.  The district health board contract requirements are met. |

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

Consumers have access to visitors of their choice.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The complaints and compliments process is easily accessible to residents and families. Policies and procedures comply with Right 10 of the Code.  The complaints register is sighted. The register includes the dates and actions taken. There have been more documented compliments than complaints, with one complaint documented in the last 12 months. Records sighted confirm that the complaint was well management and resolved in a timely manner to the satisfaction of the complainant. Staff interviewed are well versed in the complaints process and support residents and families to voice their concerns. Residents interviewed knew how to access the complaints process, and report they would be comfortable doing so. This is confirmed in the results of the 2013 satisfaction survey where 79% of residents report they understand the complaints process.  It is reported that there has been no complaints made to external agencies since the last certification audit.  The district health board contract requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The mission, vision and goals of the organisation are displayed and documented. The organisation is a charitable trust governed by a board of directors. A trust chairman is interviewed and reports that the board is currently developing the strategic plan.   The general manager is responsible for the development of the business plan. The business plan is sighted and includes the mission and values of the organisation. The business blan is approved by the board. Organisational performance against the goal of the business plan is monitored regularly through monthly general manager reports (sighted March 2014).This report includes quality related data, staffing, occupancy, risks and key components of service delivery.  Day to day operations are the responsibility of the general manager. The general manager is on site four days per week. The general manager has experience relevant to support for the older person, business management and has a quality and auditing background. The general manager is able to show evidence of exceeding the required eight hours annually of professional development activities related to the aged care sector including relevant conferences both inside and outside New Zealand. The general manager is supported by the support services manager.  The general manager’s curriculum vitae and job description are sighted and confirm accountabilities, authorities and responsibilities. The current organisational chart also confirms authorities and reporting lines throughout the organisation. The general manager’s performance is monitored by the directors and the annual performance appraisal is sighted.  The district health board contract requirements are met. |

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

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

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

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

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

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

#### Standard 1.2.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| In the event the general manager is absent, the support services manager attends to operational management and the nursing coordinator is available for clinical management. Lines of authority and responsibilities are defined in the organisational chart.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are sufficiently documented and identify quality outcomes for key components of service delivery. Policies sighted reflect the aged related contract requirements and best practice. Policy reviews are conducted every two years and updates are made by those who use them, or as changes are needed. All policies are maintained in the electronic data base and can only be changed by super users. This ensures that the current version of all policies, procedures and work instructions are available to staff at all times. Documents and controlled and review dates and version numbers are sighted on the footer of all documents. All policies are authorised/approved by the general manager. All obsolete documents are identified as such, removed from circulation and a copy maintained. Staff are alerted to changes in policies through ‘time target’ which provides them with alerts and messages when they clock in.  There is a documented quality plan. The quality plan is included in the business plan. Quality activities include monthly audits, quality meetings and improvement projects (for example falls, care planning projects and Eden initiatives). Progress towards achievement of quality goals/initiatives and activities is monitored and reviewed by the general manager.   Quality improvement data is analysed to identify trends and themes. Quality meetings occur regularly and include complaints, incidents and accidents, collated key quality indicators, health and safety, training, infection control and outcomes of audits. Minutes of meetings are sampled and confirm comprehensive discussions and data analysis. Key quality indicators are graphed for monitoring and comparison purposes. It is noted that quality improvement data is being gathered in a meaningful manner providing both qualitative and quantitative data on outcomes for residents. For example there is growing confidence that recent improvement projects are reducing the rate of falls and related incidents.  There is an internal audit schedule that is fully implemented. Audits are scheduled at regular intervals to cover the scope of the quality system. Completion of internal audits are delegated to all staff, with final sign off by the general manager. The administrator maintains a register of internal audits. Audits are sampled and confirm they are conducted as scheduled, include the required remedial actions, which are then communicated to staff. Satisfaction surveys are also conducted to confirm the organisation meets the expectations of residents/family. The 2013 results are sighted and confirm general satisfaction with services. Responses are collated into a full report with analysis (sighted).   Risk management activities and management plans are documented in the business plan. The organisation has tertiary level Accident Compensation Corporation (ACC) work safety management practices and health and safety meetings occur quarterly. Minutes of the December 2013 meeting sighted and confirm discussion regarding work place safety and hazard management. Hazards are identified, monitored and collated on the electronic risk management system. This automatically allocates risk levels and monitoring requirements.   The trust chair interviewed confirms adequate insurances are in place and that current risks are reported to the directors in the monthly general manager reports, or as needed. This is evident in board reports sighted.  The district health board contract requirements are met. Post Audit: The provider does not agree with this attainment rating. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The required incident and accident prevention, management and reporting policies/procedures are in place. Individual incident and accident reports are documented in the electronic data base. The data base is sampled and confirms that full reports, including immediate interventions and remedial actions are documented. Key quality indicators are reported for wounds, infections, pressure areas, ulcers, falls, skin tears and behaviours of concerns.  Recent incidents are sampled to ensure investigation, appropriate actions and closure. Reported incidents are taken from the data base and tracked in resident records. The incidents sampled are well documented and essential notifications are made. Emergency actions are implemented in the event of falls and critical observations documented. Communication with family members is evident and the general practitioner is notified in a timely manner. This is confirmed in both family and GP interviews.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are written policies and procedures in relation to human resource management which comply with current good employment practice.   Ten staff files are sampled. The sample includes a range of staff from both clinical and service areas. Files sampled confirm that the skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and authority.   There is a defined recruitment, orientation/induction process. Evidence of the required recruitment screening (including police checks and reference checks) and validation of professional qualifications is confirmed. All new staff receive an induction/orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures. Completed orientation checklists are sighted in files sampled.  The organisation provides in service training and there is a planned programme of on-going education. An in service training calendar is developed annually and ensures that staff meet (or exceed) the required number of hours training per year. In service training includes the topics required in the district health contract, however training on restraint and enablers (as required in standard 2.2.1) has not been consistently provided and an improvement is required.   Records of staff attendance to training sessions is maintained and individual training records are entered on to the data base. Records sampled confirm that staff working in the dementia suite have the required dementia related qualifications and all staff receive training of the Eden alternative, infection control, emergency procedures, code of rights, managing behaviours of concern, manual handling and health and safety. There is also sufficient evidence that staff involved in medication management and/or administration have completed the required competencies.  Staff performance is monitored in an ongoing manner. Performance appraisals are conducted annually as required and these are evident in all staff files sampled.   The remaining district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The induction/orientation programme includes the Eden alternative, fire safety, health and safety, facility tour, infection control and manual handling. New staff are then buddied into their respective roles and shifts. However, the management of, or definitions, regarding the use of restraints and enablers is not included in the orientation/induction training, nor is there sufficient evidence that it has been provided routinely in the in service training programme. Records of restraint training were sighted in three out of 10 staff records sampled. It is noted that restraint training has been included in the 2014 training plan for November 2014. |
| **Finding:** |
| Restraint and enabler training is not provided during orientation and there is insufficient evidence that related training is being conducted in an ongoing manner.   Post Audit: The Provider does not agree with this finding. |
| **Corrective Action:** |
| Provide training on restraint/enablers in an ongoing manner. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation employs 81 staff in total. This includes a combination of health care assistants, administration staff, auxiliary staff, maintenance, and seven registered nurses (one of whom is the nurse coordinator), six enrolled nurses, a rehabilitation coach and two life style coordinators.   There is a documented rationale for determining service provider levels and skill mix which includes the three service areas, rest home, hospital and the dementia suite. The roster is developed by a non-clinical staff member. The process for decision making is explained and the roster is randomly sampled to ensure there are sufficiently trained and skilled staff members in each area at all times. This includes staff that have completed the required aged care education, medication competencies and first aid training.   There is a registered nurse on each duty in the hospital and/or enrolled nurse on each duty in the rest home and dementia area. There is also the required number of health care assistants in each area during the day shifts. The nurse coordinator overseas all nursing duties and is on site during weekdays and on call at all times. There is one registered nurse on duty to cover the entire facility during the night shift. The night shift registered nurse is supported by one enrolled nurse in the hospital, and one health care assistant in both the rest home area and dementia suite. The general manager states that this is sufficient and has interpreted the contract requirement for staffing in a hospital level of ‘two care assistants on duty at all times’ is inclusive of the registered nurse.   There are no reports from staff or residents regarding the number or availability of staff.  The district health board contract requirements are met. |

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

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

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident records are well documented and resident files are tidy and well maintained. Each resident folder contains a contents sheet which identifies the documentation requirements for each file. Progress notes are written daily by the health care assistants and nursing notes are written as required. All entries include the date, time, name and designation of the writer. Resident records are integrated. For example: assessments and additional plans are kept in the same file.  All past and present records are stored in a secure and safe manner and are not publically accessible or observable. A register of all resident admissions since opening is sighted. This is maintained by the administrator who enters admissions and discharges as they occur. Archived records are held on site (in the attic). There is a system for ensuring records can be tracked by discharge date, month and year.  The district health board contract 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.

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

##### **Criterion 1.2.9.7 (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.

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

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

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

#### Standard 1.3.1: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy identifies entry processes which are communicated to residents, family/whanau and referral agencies. A facility enquiry form is to be completed for each enquiry and this details the potential resident details, care type required for example rest home, hospital or dementia care services and any general comments including all contact details. The resident records reviewed 10 of 10 have their assessments from the needs assessment and service co-ordination assessors Support Net NASC (LDHB) prior to admission or alternatively the geriatrician at LDHB and/or the psychiatrist geriatrician at LDHB from mental health services (MHSOP) for older people filed appropriately in the individual integrated records.  Three rest home, three dementia care and four hospital level records were reviewed. A copy of the enduring power of attorney is also retained in records if available. There is a comprehensive report with all support needs being identified and summarised with options for meeting the needs and goals established, plus the outcome of the nursing assessment is documented and the residential client agreement if possible is verified.  The district health board contract 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.

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

#### Standard 1.3.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy describes processes undertaken should entry to services be declined. This includes notification to appropriate persons and agencies. If a potential resident does not have the appropriate assessment completed and/or is declined entry to the service, the admission form and notes record the communication with the referrer or the alternative service.  The clinical manager at interview reports that entry has not been declined for any rest home and hospital level care residents, but if a resident in the dementia service/Manaia Suite required a higher level of care or a different or more appropriate environment to meet individual needs a referral this is sent by the GP for a re-assessment to be completed by the Support Net NASC service of mental health services for older persons psychiatrist/geriatrician. A record is maintained in the resident register. The resident`s family/whanau are kept well informed by the clinical manager.  The district health board contract 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The development of the resident’s individual support plan is guided by service policy. The clinical manager explains that the staff work collaboratively with the resident and the resident’s family/whanau, advocate or representative to complete the resident’s support plan. The registered nurses (seven) are assigned a new resident to follow and they are responsible for completing the initial assessment and later the resident support plan for the individual resident. The initial assessment and support plan is to be developed within twenty four hours of admission and the residents support plan within three weeks of admission to the rest home, dementia or hospital services. The 10 of 10 support plans reviewed are evaluated six monthly by the registered nurses or more frequently if the resident’s condition or health status changes significantly. Evaluation includes consultation with the resident, the multidisciplinary team consisting of the physiotherapist, activities staff, GP, social worker if needed, resident`s family and/or advocate. The date of this review is recorded on the front cover of each individual record sighted with the month due, person responsible and ticked off when completed and the next due date.   The staff handover was sighted in the middle of the afternoon when the staff changes occurred. Each staff member has a printout of the residents in their care and the staff discuss each resident and any identified needs to be met. This process, a quality initiative to improve communication works well for the three services provided and staff feel more confident about speaking out about residents and cares required.  Each stage of service delivery is undertaken by qualified and suitable skilled staff. The seven of seven registered nurses conduct the initial assessments for each individual on admission, the initial care plan and within three weeks develop and ensure the implementation of the resident’s support plan. When the residents’ support plans are reviewed there are various recognised assessment tools available to use depending on the identified needs of the resident for example Braden scale, Tinetti falls risk index are identified, continence assessment, nutritional assessments and others are available. Any risk factors are identified and signed off by the registered nurse.  Residents interviewed, three rest home and three hospital and two families interviewed separately, report high satisfaction with the care and the services provided. The clinical staff interviewed including the clinical manager, two registered nurses, one registered nurse receiving orientation, three senior health care assistants, the GP and the rehabilitation therapist confirm that team work is encouraged and continuity of care is promoted at all times. The one GP interviewed cares for a number of residents at this facility and visits regularly and meets appropriate timeframes for admission, for all reviews inclusive of the medication reviews done three monthly or more often if required. The GP will visit after hours if and when required.   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 care: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  The district health board contract 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.

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

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

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

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

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

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

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

#### Standard 1.3.4: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Assessments are sighted for dietary requirements, falls, neurological observations, pain, skin management and wound assessment and other recognised tools.  The 10 of 10 residents` records (three rest home, three dementia unit and five hospital) evidence appropriate assessments have been performed when a need is clearly identified. Interventions for this are recorded on the resident’s support plan that is pre- documented. Staff tick or add comments relevant for that resident to meet the set goals. All resident’s files reviewed evidence falls risk assessments. Where there is a moderate to high falls risk, additional falls and balance assessments are conducted by the contracted physiotherapist and specific plans are developed to reduce falls. The rehabilitation therapist carries out instructions as per the physiotherapist plan of action completed and dated by the physiotherapist. The NASC assessments are taken into consideration and are used to serve as the basis for service delivery planning. The two of two family interviewed report their family member receives care that meets their needs adequately. The nurse co-ordinator and one registered nurse are fully trained in InterRAI but this has not been implemented. All registered nurses have been booked into the training programme to be completed by October 2014.  The district health board contract 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.

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

#### Standard 1.3.5: 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The 10 of 10 resident support plans reviewed inclusive of three rest home, three dementia and four hospital level care have a standardised format that is individualised to the resident`s assessed needs. The resident support plans for the rest home and hospital level residents identify the resident’s needs and care requirements with specific plan to respond to reducing falls, increase mobility, maintain independence, maintain weight as examples. The records reviewed are integrated and contents page identifies what information is in each section and is helpful for filing purposes.  Input from the multidisciplinary team members is included in all records sighted. The handover observed includes updates of all residents, results of laboratory tests is also provided. The two of two family interviewed separately and six of six residents (three rest home and three hospital) interviewed report a high level of satisfaction with the quality of care provided at these services. The dementia service is well managed and staff are all very qualified to work in this area of service all of whom have completed their dementia care training and all but one new staff member has completed the advanced dementia series (career-force training package). The resident support plans have the goals already documented and the interventions are documented and if not applicable this is clearly documented on the support plan. There is an area of improvement identified in relation to the resident support plans three of three reviewed for the dementia residents. There is no mention in the support plans of the current abilities, level of independence, deficits and as far as is practicable their personal preferences, individual habits, routines and idiosyncrasies of each resident to verify adequate and appropriate interventions are currently being documented to guide staff appropriately.  The district health board contract requirements are not all 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The resident support plans were randomly reviewed three for the rest home, four for the hospital and three for the dementia service. The support plans describe briefly the support and/or intervention linking with the Eden Alternative Philosophy taken into consideration and with a less clinical focus. |
| **Finding:** |
| There is no mention in the resident support plans for the dementia level residents of the current abilities, level of independence, deficits and as far as practicable their personal preferences, individual habits, routines and idiosyncrasies.  Post Audit: The provider does not agree with this finding. |
| **Corrective Action:** |
| To identify and ensure the resident needs are clearly identified and describe appropriate support and/or intervention to achieve the goals identified by the ongoing assessment process. |
| **Timeframe (days):** 180 *(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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The interventions for meeting the personal cares and other requirements for residents is clearly documented under each goal which requires a clinical intervention documented beside each entry. The residents support plan covers hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest, sleep, communication, helplessness, loneliness and boredom, spiritual, emotional and cultural. Goals preferences and abilities are documented in conjunction with the Eden Alternative with no clinical interventions documented. The evaluation is documented and covers all of the goals. A comment is documented when reviewed for each section, and signed by the registered nurse with full designation and signature and the date of making the entry when completing the evaluation process.  The service has adequate dressing and continence supplies to meet the needs of the assessed residents. The 10 of 10 resident support plans are documented that are mostly consistent with the resident`s assessed needs and desired goals. Observations on the day of audit indicate residents receiving care that is consistent with the resident`s needs. The six of six residents and two of two family interviews report that the service meets the needs of the resident. The three health care assistants interviewed report that the resident support plans are accurate, up to date and do reflect individual resident`s needs in the rest home and hospital. More input is required as per 1.3.5.2 for the dementia care residents.   The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are four staff that manage the activities for this service. Two staff work full time and two staff work on a part time basis. Two staff work daily on Monday – Wednesday and four staff manage the Thursday and Friday sessions. There is still activities planned in the weekend four hours a day. Volunteers from the community are available to assist with the programme. The activities programme is displayed monthly in each area of the service and daily on the whiteboard at reception/entrance to the rest home (Eden surprise). The staff align the individual residents’ needs with the 10 Eden Alternative principals which are displayed in the rest home, hospital and the dementia services. A copy is retained in each individual resident file reviewed. This was implemented two years ago. The activities staff two of two interviewed explain with passion how information is sought from each resident, inclusive of choice of activities they enjoy, church affiliations, and other information. A “My Life” assessment is completed on admission to the service for each resident. Information is documented briefly on the support plan.   Groups from the community to entertain are encouraged. Local school children are always welcomed and enjoyed by the older residents and younger disabled as confirmed by resident interviews. There is a key on the programme as to which lounge activities have been arranged and are to be held. A list of resident`s birthdays is displayed and the days for shopping, holy communion and the date of the next monthly residents meeting 15 May 2014 is clearly documented. One on one groups are provided between activities that are scheduled on the programme. Special moments are part of each session and an activity that residents are not aware of for example a special morning tea, dogs visiting, staff dressing up or other fun activities or entertainers. Every Friday afternoon there is happy hour.  The district health board contract requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Nursing reviews and assessments, medical and specialist consultations and admission and discharge summaries are clearly documented in 10 of 10 residents` records reviewed. The resident support plans are reviewed six monthly and more often if required. If a resident is not responding to the service interventions or their health status changes then this is discussed with their GP and the GP interviewed validated this information. Family are notified and this is documented on the progress records. Short term support plans are used for wound care, infections, changes in mobility status (physiotherapist would be involved), changes in food and fluid intake and skin care. These processes are clearly documented on the short term support plan, medical and nursing assessments and the residents` progress records.  There is evidence of family/whanau/resident input into the six monthly reviews. Family members report that they can consult with staff at any time if they have concern or there are changes in the resident`s condition.   The district health board contract requirements are met. |

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

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

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

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

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

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

#### Standard 1.3.9: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The residents are provided with options if required to access other health and disability services. The residents have a choice of which GP they choose or retaining their own GP in the community. There is one GP who cares for the majority of the residents at this facility. The GPs can arrange a referral to specialist/medical/ surgical services if and when necessary. The GP interviewed reports that the referral services respond promptly to referral sent. Records of the process maintained is confirmed in the 10 of 10 records reviewed, which include referrals and consultations with, for example; respiratory specialists/clinics, urology, radiology, cardiology or the contracted dietitian. The GP interviewed reports that appropriate referrals to other health and disability services are well managed.  The district health board contract 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.

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

#### Standard 1.3.10: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The clinical manager interviewed confirms that if a resident`s condition or health status changes the GP is notified. Should a resident require service higher level care, being more for the dementia care or rest home resident requiring hospital level care, a referral is sent to the NASC service for a reassessment to be performed. When approved if in the case of a dementia care resident needing higher level dementia care once the outcome has been approved assistance is provided to find a more suitable service provider.  If a resident requires transfer to public hospital, the GP contacts the service required first and then the transfer is arranged by the nursing staff. In an emergency situation the resident is transferred immediately and the GP informed as well as the clinical manager by the registered nurse. Transportation is arranged usually by ambulance. There is a Whare Aroha Care discharge/transfer form which is completed when transferring to LDHB or other facility. Full details of the resident and family/whanau contact details are provided and a checklist of things for staff to send is clearly documented. General health status information inclusive of psychological/cognitive assessment, wounds, daily living needs and nutritional requirements. The resident register is maintained and a record noted in the resident`s individual record of the admission or transfer.  The district health board contract 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.

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The organisation has appropriate policies and procedures in place to reflect safe and timely medicines management. Procedures comply with current legislative requirements. There is pharmacy involvement in the reconciliation process and evidence of pharmacy input into the medication records. Photo identification of each resident is available on the medication record sheet and the signing sheet and in the medical records. There is a signature verification list available.  Staff who administer medicines have set competency assessments and are deemed competent. Education records evidence training has occurred and that training is ongoing. Full training was provided for all staff for the changeover to the newly implemented medication system now is use. There are three senior health care assistants who have completed the ACE programme and are undertaking the advanced ACE course who are able to administer medication when required in the rest home. The registered nurses seven of seven and the enrolled nurses six of six (under the supervision of the RNs) are all responsible for the medication administration processes. The controlled drug system was verified and the medications are checked on a regular basis by two registered nurses on night duty weekly and six monthly checks are completed by the contracted pharmacy and stored appropriately to meet legislative requirements. Fridges containing medication are monitored regularly and records are available.  There is a policy in place for residents who wish to self-administer medicines. No residents self- medicate presently.  The clinical manager is over all accountable for the medicines management. The registered nurses interviewed demonstrate how the medication is ordered and is delivered to the pharmacy. When the medication packs arrive fortnightly on a Thursday from the contracted pharmacy they are checked and the pharmacy notified if there are any issues. There are four medication trollies, two for the hospital (Wairua Suite), one for the rest home (Manaaki Suite) and one for the dementia service (Manaia Suite). The Robotic system is implemented and the medication is stored in the trollies. The system is functional and the lunch time medication round was observed in Wairua Suite and Manaia Suite. All trollies when not in use are stored in the medication rooms and the trollies are locked. There is key pad access to all three medication rooms.  Twenty two medication records were reviewed, six of six rest home, six of six dementia services and 10 of 10 hospital level. There is evidence of the three monthly reviews of medication occurring and/or earlier if required by the GPs and this is recorded on the medication records. There are three signing records pink antibiotics, red for controlled drugs and yellow for short term course medications. All known allergies and/or any sensitivities are clearly documented and bright orange allergy stickers are used. There is an area of required improvement in relation to medicine management as one GP is bracketing all medications and signing the signature for all prescribed medications with the one signature and not each medication individually. Advice was sought from HealthCERT at the time of the audit as this practice is observed on most of the medication records reviewed and has been a corrective action for several audits for this service.  The district health board contract requirements are not all met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Twenty two resident medication records were randomly selected for review. The medication management system is implemented safely and managed well by the staff who are educated and competent to manage this system efficiently and effectively. |
| **Finding:** |
| On review of the medication records it was observed that one general practitioner is bracketing the prescribed medications and signing off all medications with the one signature. |
| **Corrective Action:** |
| To ensure each prescribed medication is signed off individually on the medication record by the general practitioner. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The food is prepared in the kitchen and produced in accordance with the menus and recipes provided and under hygienic conditions to provide food of the highest possible standard and to be free from potential food safety hazards. All food preparation is undertaken within appropriate areas using appropriate staff and equipment. Bain-marie are used to transport the hot foods due to the distance from the kitchen to the service areas. Waste is disposed of as per the waste management policy. Recycling occurs throughout this facility.   The main cook is experienced and has been in this role for six years. They work Tuesday to Friday and another cook covers the other days. The menus are planned for summer/winter and have been audited by two registered dietitians and a letter to verify this audit was dated 24 December 2011. The menu is displayed around the facility and in the kitchen a large whiteboard is used. The dietitians ensure that appropriate guidelines are used for the meal service especially for the older residents or disabled persons irrespective of age. The cook has a job description for the role and part of the role is to monitor for health and safety purposes the fridges/freezers used for food preparation and storage. Temperature monitoring is recorded by the cook and this is available and sighted. The dry stock is rotated in the pantry, sighted. All food is ordered by the main cook who has a system in place for ordering supplies as necessary.  The registered nurses identify when performing the comprehensive assessment on admission whether a resident has any known food allergies and/or sensitivities and these would be reported directly to the cook. An allergy sticker is also placed on the resident`s individual record as an alert for staff. Preferences of all residents and dislikes are recorded by the cook. Special diets can be arranged such as gluten free, diabetic or low fat diets as needed. The dietitian can provide advice if and when required. Special dietary aides are available as needed for example the lip plates and feeding cups. Additional caloric preparations can be prescribed by the GP or the dietitian as needed for individual residents to meet their identified needs. Two of two families interviewed separately and six of six residents (three rest home and three hospital) reported satisfaction with the food service and stated that food is well presented for the residents. Staff are available to assist residents at meal times and this was sighted at lunchtime in all service areas.  Special days such as birthdays, Christmas, Easter are celebrated and special functions for the organisation are assisted by the kitchen staff. All staff working in the kitchen have received education on infection control and food handling certificates were sighted in the staff files and the two cooks have their own records available. Food handling certificates from Waiariki Institute of Technology dated the18 October 2006 and 11 September 2006 are sighted. Both have completed NZQA167 and NZQA20666 food safety courses.  The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

#### Standard 1.4.1: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are adequately documented procedures for the management of waste and hazardous substances and emergency and chemical data safety sheets are stored with the chemicals. Hazardous substances include domestic rubbish, domestic chemicals, hygiene products, single use items and blood/body fluids/products. These are identified on the current hazard register. Cleaning chemicals are kept secure and sufficient protective equipment is observed. Staff receive sufficient training on the management of waste and hazardous substance and there have been no reported incidents/accidents regarding same.  The district health board contract requirement is 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.

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

##### **Criterion 1.4.1.6 (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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building and facilities are well maintained and suitable for the care and support of residents requiring rest home, hospital and secure care. The facility was originally a nursing home and is divided into three separate areas. The rest home and dementia suite are on the ground floor, with hospital level care upstairs. All areas provide a range of different indoor settings and there are low stimulus areas in the dementia suite.   Applicable building regulations and requirements are met. The current building warrant of fitness is sighted and expires in December 2014.  The facility is set on sufficiently sized grounds and gardens. There are evenly surfaced pathways and external seating in the gardens. Ramps are kept moss free with safe handrails. There is adequate parking for both staff and visitors. The dementia suite has a secure garden area which enables residents to wander safely.  There are separate lounge and dining spaces in all three areas. The corridors and doorways are wide enough to accommodate equipment and mobility aids. There is adequate furniture and equipment throughout. Equipment is observed to be well maintained, calibrated and appropriate to the needs of residents. All areas have sufficient equipment including hoists, chairs, scales, sensor mats and hospital beds. Environmental hazards are identified and monitored.  A maintenance person is on site during week days and records sighted provide evidence of ongoing maintenance activities. A maintenance book is kept in each area where requests can be made and monitored. Additional records sampled include gas and plumbing boiler maintenance schedules, electrical compliance certificates, security systems and service detail reports for kitchen and laundry appliances.   Residents interviewed report no concerns regarding the facility and grounds and the 2013 survey results confirm that the majority of residents feel the facility is well maintained (55% always and 41% most of the time).  The district health board contract requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

##### **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.

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

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

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

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

#### Standard 1.4.3: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bathrooms and toilet facilities are shared. These are sufficient in number and well maintained in line with infection control requirements. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities. Bathroom facilities can accommodation equipment if required and there are two bath trolleys in the hospital area. It is reported that these are well used. There is a small hand basin in each bedroom. Water temperatures are monitored and records sighted confirm that hot water is maintained at a safe temperature.  The district health board contract 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.

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

#### Standard 1.4.4: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents have private rooms, with the exception of one shared room in the dementia suited which is shared by a couple. All rooms have adequate space for equipment and care. Residents and family members interviewed voiced no concerns regarding personal space/bed areas. Bedrooms sighted are decorated with personal items. This includes bedrooms in the dementia suite.  The district health board contract 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.

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

#### Standard 1.4.5: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All areas have adequate and well furnished lounge and dining areas. These areas are well utilised and sufficiently sized. Low stimulus areas are available. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. There is a physiotherapy/exercise room upstairs which is used by all residents. On the day of the audit this was being utilised by three residents from the dementia suite.   The district health board contract 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.

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

#### Standard 1.4.6: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All laundry is completed on site by trained laundry staff. Dirty linen is sorted into colour coded laundry bags and transported to the laundry. The laundry has well defined processes for the management of clean and dirty linen with clearly defined clean and dirty areas, plus a drying room. Industrial washing and drying machines are used and chemicals are provided through a closed chemical circuit system. Laundry staff interviewed confirm attendance at chemical and infection control training.  Designated cleaning staff use well stocked cleaning trolleys. All cleaning products are labelled and the cleaning trolleys are safely stored when not in use. Cleaning and laundry hazards are documented and material data safety sheet are displayed. There is adequate personal protective equipment is sighted throughout the facility. Cleaning and laundry staff have access to documented cleaning and laundry guidelines.   Satisfactions with cleaning and laundry activities is monitored through surveys. The 2013 survey confirms that 69% of residents felt that cleaning standards were very good and 24% good. Satisfaction with laundry services was at 31% very good, 24% good, 21% fair (21% did not answer).  The district health board contract 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.

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

##### **Criterion 1.4.6.3 (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.

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

#### Standard 1.4.7: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. There are security cameras and a working call bell system throughout the faciltiy (including the dementia suite). There is a security code on entry to the dementia suite.   The fire service has approved the current evacuation plan for the facility (dated 2001) and records of biannual fire evacuations are sighted. Fire systems and emergency evacuation equipment is checked as required. A sprinkle system is in place and evacuation procedures are sighted throughout. The building is seperated by fire doors and evacuation is a three step process. There is a designated fire warden on each duty. In addition, there is signage in each resident’s room which identifies the level of support required during mobilisation. This can be used a a quick reference during an evacuation.The most recent fire evacuation occurred in January 2014.   Disaster plans are documented for a range of emergencies and outbreak management and pandemic planning is documented in line with the district health board guidelines. Adequate civil defence supplies are available and include the required equipment and stores. There is adequate food and water supplied in the event of an emergency. The building has a generator in the event of a power failure and there is a BBQ and stored gas bottles.    All staff receive training in the management of emergencies during orientation and thereafter six monthly during fire evacuation training/drills. There is also adequate staff on each duty with first aid training.   The district health board contract 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.

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

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

Where required by legislation there is an approved evacuation plan.

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

##### **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.

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

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

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

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

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

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

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

#### Standard 1.4.8: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has plenty of natural light throughout. All rooms have at least one good sized window and temperature is maintained through the use of panel heating on the ceiling and heat pumps. There are no concerns voiced by residents, or family regarding the temperature of the facility.   The district health board contract 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.

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

##### **Criterion 1.4.8.2 (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.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are in place to ensure any restraint minimisation and safe practices are actively minimised. Policy identifies enablers are voluntarily used by a resident following appropriate assessment. When an enabler is to be used consent is sought and documented. There are seven residents using enablers presently in the form of a bedside rail. Reviews occur three monthly. The approval committee consists of the health and safety representative, clinical manager, one registered nurse and one GP.  During discussion with clinical staff they clearly demonstrate knowledge and understanding of the definition of an enabler and the process required to be followed should restraint be used. Staff education related to restraint minimisation includes management of challenging behaviour. Education is part of the orientation process and is compulsory annual education. The use of enablers is voluntary and the least restrictive option to meet the needs of the residents. Enabler use is discussed at the multi-disciplinary review meetings.   The district health board contract 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.

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

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

#### Standard 3.1: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The nurse coordinator is the designated infection control coordinator and the responsibilities for the role are clearly defined. The nurse coordinator reports to the general manager. The infection control programme is clearly documented in the buisness plan and is suitable for the facility and the scope of the service. The annual review of the infection control programme ensures that infection prevention and control processes are up to date. This was last completed in July 2013.  Residents, staff and visitors are protected from the spread of infection through signage, training and adequate equipment and resources. Staff and residents are offered influenza vaccinations.  The district health board contract requirement is 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.

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

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

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

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

##### **Criterion 3.1.9 (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.

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

#### Standard 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

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme defines appropriate responsibilities for the infection control coordinator and staff that are appropriate for the service. There is designated time and resources provided for infection control activities.  The infection control coordinator is a nurse with relevant skills and expertise to implement the programme and has completed bug control training. The coordinator also has access to current information relevant to the size and complexity of the facility including infection control manuals, expert advice from Bug Control and laboratory specialist.  Review of resident records indicate that an infection record is maintained for each resident. The resident care plan sample includes review of any infections and the outcome of treatment. There is documented evidence that the coordinator gathers monthly reports on infection related issues. Staff meeting minutes and interviews with the general manager and health care assistants confirm that information regarding infections is effectively communicated. The general practitioner is also informed if a resident has an infection.  The district health board contract requirement is 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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Documented policies and procedures are in place for the prevention and control of infection. The protocols are appropriate for the facility and reflect current accepted good practice and legislative requirements. Policies and procedures are developed and reviewed and the 2013 bug control manual is sighted.  Policies and procedures include hand washing, cleaning and sterilisation, standard precautions, isolation, outbreak management, management of staff with infections, health and safety, and a list of notifiable diseases. A pandemic plan is documented and standard definitions are used for surveillance reporting.  The district health board contract requirement is 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.

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

#### Standard 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Insevice education on infection prevention and control is provided by a suitably qualified person.The infection control coordinator is a registered nurse and has completed bug control training.  Education in infection prevention and control is provided during orientation and in an ongoing manner. Training records sampled confirm that in-service education has been provided in the last 12 months. Health care assistants interviewed advise education to residents primarily includes the prevention of spreading infections and assisting with hand hygiene.  The district health board contract requirement is 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.

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

##### **Criterion 3.4.5 (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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection surveillance programme is appropriate for the facility and the level of care provided. Individual incident reports are documented and collated monthly. These include signs, symptoms, type, specimen type and date, organism found and antibiotics prescribed. This information is collated and trends are reported.   Quality infection control meetings are conducted fortnightly and these confirm ongoing discussion regarding the infection control programme and reports of key quality indicators. The organisation has a low rate of infections and no outbreaks have been reported since the last certification audit. |

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

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

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

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

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

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