# Eileen Mary Age Care Limited

## Current Status: 27 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

Eileen Mary Aged Care Ltd is a 58 bed rest home and hospital facility in Dannevirke. It is one of two aged care facilities owned privately by one owner. The facility remains in the same configuration since its last on site audit event. A new facility manager has been appointed who was previously a registered nurse in the facility. There have been no significant adverse events and no external complaints.

This certification audit has identified no areas requiring improvement. There has been a consistent process of addressing the areas identified for improvement in the past and in ensuring that the service provides a high standard of service delivery. One area of continuous improvement is noted.

## Audit Summary as at 27 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 27 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 27 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

### Continuum of Service Delivery as at 27 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 27 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 27 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 27 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 27 May 2014

### Consumer Rights

Care provided to residents at Eileen Mary Aged Care Ltd (Eileen Mary) is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Eileen Mary does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is available at the resident’s request and the diversional therapist facilitates regular residents’ meetings. Eileen Mary encourages residents to maintain connections with family, friends and their community and encourages people to access as many community opportunities as possible.

Complaints are managed openly. The facility manager handles responses to all complaints and they are recorded in a database, which is current and up to date. Residents and family/whanau receive information about how to make a complaint on entry to the service and staff understand their responsibilities for supporting people to make a complaint. There is open communication and residents, family/whanau and staff report the facility manager welcomes feedback about the service.

### Organisational Management

There is oversight of both facilities by a general manager based at the sister facility in Fielding. She reports weekly to the owner who provides governance to Eileen Mary both through the general manager and visiting when needed. The facility manager is an experienced registered nurse who maintains her practising certificate. She has been well supported by the organisation in the transition from the previous manager. An area of strength is identified in relation to the management of the service. The service goes beyond full attainment of the standard by identifying improvements to the structure of the organisation, implementing these and evaluating the impact of these changes.

Both Eileen Mary and its sister facility are moving towards one consistent quality management system and this is being effectively implemented.

Quality and risk management systems are in place and incorporate the requirements of the standard. Adverse events are reported and recorded and there is a transparent process for managing all exceptions, which includes communication with family/whanau.

The organisation has human resources management processes which are aligned with good employment practices. Staff have supervision and annual appraisals. Accountabilities of all positions are clearly defined. Training and development of staff occurs and those staff members who hold professional registrations are supported to complete their required development commitments. In-service training is available on a continuous cycle. External expertise is utilised when this is the most effective solution and external training opportunities are similarly accessed.

There is a four days on/two days off roster for most positions in the rest home, and safe staffing levels are maintained across the facility. Interviews with residents, family/whanau and staff members provide evidence that there are adequate numbers of staff on all shifts.

Each resident has an individual record of care which is maintained and current. Resident information is held confidentially and all records are integrated. There is secure storage on site of residents’ records and associated documents and this includes archived records.

### Continuum of Service Delivery

Information packs for Eileen Mary contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment and Co-ordination Service (NASC) to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family.

An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice.

Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

### Safe and Appropriate Environment

The Eileen Mary facility is purpose built for the provision of aged care residential services. The environment is very well maintained and promotes safety, wellbeing and comfort for the residents who live there. The facility has a current building warrant of fitness and fire and emergency systems are maintained.

The organisation has all required systems and processes for the management of waste and hazardous substances, cleaning and laundry services. Systems for maintaining the environment are monitored by staff members with appropriate responsibilities and authority to ensure that the high standard required by both the owner and management team are met.

Rooms are personalised and promote safety and comfort. Communal areas both inside and out, are easily accessed by residents and the facilities and furnishings are appropriate to the needs of residents.

### Restraint Minimisation and Safe Practice

There is an environment which focuses on restraint minimisation and safe practice. The organisation has a process which ensures all requirements of this standard are met. Staff members are trained in restraint minimisation and safe practice processes to support residents safely. The use of enablers is voluntary.

All restraint use is evaluated three monthly and the facility manager, who is the restraint coordinator, reviews all approved restraints every six months. Restraint and enabler use is incorporated into the organisation’s quality improvement processes and data is included in the facility manager’s monthly report.

### Infection Prevention and Control

The service is able to demonstrate it provides a managed environment, which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the general manager. There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse (who is also the facility manager) is responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance.

# 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:** | Eileen Mary Age Care Limited |
| **Certificate name:** | Eileen Mary Age Care Limited |

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

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| --- | --- |
| **Types of audit:** | Certification Audit |
| **Premises audited:** | Eileen Mary Retirement Complex |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 27 May 2014 | **End date:** | 28 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:** | 58 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXX | **Hours on site** | 16 | **Hours off site** | 12 |
| **Other Auditors** | XXXXXXX | **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** | XXXXXXX |  |  | **Hours** | 4 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 24 | Total audit hours | 56 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 11 | Number of staff interviewed | 12 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 51 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group 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 The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group 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) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Friday, 20 June 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Eileen Mary Aged Care Ltd is a 58 bed rest home and hospital facility in Dannevirke. It is one of two aged care facilities owned privately by one owner. The facility remains in the same configuration since its last on site audit event. A new facility manager has been appointed who was previously a registered nurse in the facility. There have been no significant adverse events and no external complaints. This certification audit has identified no areas requiring improvement. There has been a consistent process of addressing the areas identified for improvement in the past and in ensuring that the service provides a high standard of service delivery. One area of continuous improvement is noted.  |

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| **Outcome 1.1: Consumer Rights** |
| Care provided to residents at Eileen Mary Aged Care Ltd (Eileen Mary) is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. Eileen Mary does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required. Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events. A local independent advocate is available at the resident’s request and the diversional therapist facilitates regular residents’ meetings. Eileen Mary encourages residents to maintain connections with family, friends and their community and encourages people to access as many community opportunities as possible.Complaints are managed openly. The facility manager handles responses to all complaints and they are recorded in a database, which is current and up to date. Residents and family/whanau receive information about how to make a complaint on entry to the service and staff understand their responsibilities for supporting people to make a complaint. There is open communication and residents, family/whanau and staff report the facility manager welcomes feedback about the service. |

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| **Outcome 1.2: Organisational Management** |
| There is oversight of both facilities by a general manager based at the sister facility in Fielding. She reports weekly to the owner who provides governance to Eileen Mary both through the general manager and visiting when needed. The facility manager is an experienced registered nurse who maintains her practising certificate. She has been well supported by the organisation in the transition from the previous manager. An area of strength is identified in relation to the management of the service. The service goes beyond full attainment of the standard by identifying improvements to the structure of the organisation, implementing these and evaluating the impact of these changes.Both Eileen Mary and its sister facility are moving towards one consistent quality management system and this is being effectively implemented. Quality and risk management systems are in place and incorporate the requirements of the standard. Adverse events are reported and recorded and there is a transparent process for managing all exceptions, which includes communication with family/whanau. The organisation has human resources management processes which are aligned with good employment practices. Staff have supervision and annual appraisals. Accountabilities of all positions are clearly defined. Training and development of staff occurs and those staff members who hold professional registrations are supported to complete their required development commitments. In-service training is available on a continuous cycle. External expertise is utilised when this is the most effective solution and external training opportunities are similarly accessed. There is a four days on/two days off roster for most positions in the rest home, and safe staffing levels are maintained across the facility. Interviews with residents, family/whanau and staff members provide evidence that there are adequate numbers of staff on all shifts. Each resident has an individual record of care which is maintained and current. Resident information is held confidentially and all records are integrated. There is secure storage on site of residents’ records and associated documents and this includes archived records.  |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Information packs for Eileen Mary contain information on entry criteria, fees payable, service inclusions/exclusions and residents’ rights. The organisation works closely with the Needs Assessment and Co-ordination Service (NASC) to ensure access to service is efficient whenever there is a vacancy.There is evidence that residents’ needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated and planned in participation with the resident. All residents’ file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family. An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. Well defined medicine policies and procedures guide practice.Menus are reviewed by a dietician. Any special dietary requirements and need for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.  |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The Eileen Mary facility is purpose built for the provision of aged care residential services. The environment is very well maintained and promotes safety, wellbeing and comfort for the residents who live there. The facility has a current building warrant of fitness and fire and emergency systems are maintained. The organisation has all required systems and processes for the management of waste and hazardous substances, cleaning and laundry services. Systems for maintaining the environment are monitored by staff members with appropriate responsibilities and authority to ensure that the high standard required by both the owner and management team are met. Rooms are personalised and promote safety and comfort. Communal areas both inside and out, are easily accessed by residents and the facilities and furnishings are appropriate to the needs of residents.  |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is an environment which focuses on restraint minimisation and safe practice. The organisation has a process which ensures all requirements of this standard are met. Staff members are trained in restraint minimisation and safe practice processes to support residents safely. The use of enablers is voluntary. All restraint use is evaluated three monthly and the facility manager, who is the restraint coordinator, reviews all approved restraints every six months. Restraint and enabler use is incorporated into the organisation’s quality improvement processes and data is included in the facility manager’s monthly report.  |

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| **Outcome 3: Infection Prevention and Control** |
| The service is able to demonstrate it provides a managed environment, which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the general manager. There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse (who is also the facility manager) is responsible for this programme, including education and surveillance.Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.2: Service Management  | 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.  | CI | **Evidence**: The FM is responsible for the clinical leadership of the facility as well as day to day management and operations. There is oversight from the GM, who is based in the ‘sister’ facility in Fielding. The Eileen Mary management team is made up of the FM and an office manager (OM) who provides administrative support to the FM as well as being responsible for administrative systems of the facility. The GM reports at interview that the FM has made the transition from RN to FM effectively and that she is respected by staff. A recent (April 2014) resident and family satisfaction survey demonstrates a 96% strongly agree or agree that the service is well managed. Other aspects of the survey (clinical and medical services, house-keeping, food, diversional therapy, and laundry) range between 88% and 99% satisfaction. A range of residents, family members, external health professionals and Eileen Mary staff members were interviewed and report a similarly high level of satisfaction with the service and the way it is managed.In a temporary absence of the FM several initiatives are put in place. The GM increases the frequency of her visits. (She is also available to contact by phone when she is at the other facility.) The office manager (OM) has oversight of the house-keeping (cleaning and laundry) and food services. One RN on each shift is identified as the lead staff member who will undertake the management role if needed. The FM will go on six months parental leave at the beginning of June (returning in early December). During this absence a more formal arrangement to cover the FM role is planned. This includes the GM visiting and working in the facility for two days a week. An experienced RN will take on the FM role for the other three days of the working week. Over weekends and evenings the existing arrangements apply. A continuous improvement rating is identified against this standard. The service achieves beyond full attainment of this standard. The GM completed a service delivery restructure in August 2012 and developed a plan to improve service delivery through changes in the staff structure and the delivery of care. The current facility manager was appointed to the role in December 2012, and, working with the GM, the changes to the staff structure and model of care were implemented. In preparation for the facility’s recertification audit, and with the results of the April 2014 satisfaction survey, the GM reviewed the changes made to the management of the service. This is documented in a written report provided to the audit team during the onsite audit. The customer satisfaction survey is divided into a number of different areas, including clinical, medical, food, laundry and house-keeping services, and safety and security all rate in the mid-90th percentage. Diversional therapy and administration rate in the high 80 percentage. The overall result from the survey is a 96% satisfaction rate. At interview with a wide range of staff (12) there is a consistent message of clear communication from the management team, improvement in the way the facility is managed and increased satisfaction by staff members. One of the 12 staff members interviewed commented that the from the interview stage through to their orientation the process has been very professional and well planned. Interviews with a range of family members and residents provide a clear message of satisfaction with individual staff and the service as a whole. |

# 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:** |
| Eileen Mary Aged Care Ltd (Eileen Mary) is observed to provide an environment in which residents receive services in accordance with human rights legislation. On admission all new residents and their family/whanau receive an information pack which includes the complaint policy and contact details for the Health and Disability Commissioner (HDC) and all staff are familiar with the Code of Health and Disability Services Consumers’ Rights (the Code) as evidenced by staff training records( eight of eight) and staff (12 of 12), family (one of one rest home resident family member and three of three hospital residents family member) and resident (eight of eight rest home residents and three of three hospital residents) interviews.  Clinical staff are observed to explain procedures being undertaken, seek verbal acknowledgement for the procedure to proceed prior to it being commenced, residents' privacy being protected (eg, notes being locked away, confidentiality of information, cordless phone to make phone calls, staff knocking on residents' doors prior to entering their rooms), and residents being addressed by a preferred name. Compliance with the Code is monitored through resident and relative satisfaction surveys and this is verified by interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau.  The ARRC requirements are met. |

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

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

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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 1.1.2: 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:** |
| Eileen Mary provides an environment in which residents are informed of their rights. Residents are made aware of the Code, receiving a copy of the Code in the admission pack. The pack also includes information on the Nationwide Health and Disability Advocacy service, access to support services, the Ministry of Health’s (MOH) information on long term residential care for older people, information on applying for a residential care subsidy, and the facility’s outlining its range of services and costs.Information about the Nationwide Health and Disability Advocacy Service, the Code, the Ministry of Health’s (MOH) information on long term residential care for older people and the complaints procedure is also displayed in the reception area and is easily accessible. A local pastor is available as a residents’ advocate if required. Advice to accessing interpreters is available should assistance be required to provide the information in a language and format that is suitable to the consumer. Admissions are undertaken by the Facility Manager (FM) or Registered Nurse (RN) and all the content of admission pack information and the details in the admission agreement is discussed and clarified. Management has an open door policy. The Facility Manager (FM) or the Registered Nurse (RN) is always available for explanation, discussion and clarification about the Code with the resident and their family/whanau at any time, as verified by interview.The ARRC requirements are met. |

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

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

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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:** |
|  |
| **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 1.1.3: 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:** |
| Eileen Mary provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence.There are a range of policies and procedures which describe how residents’ privacy, independence and dignity is respected.All bedrooms are single or couple occupancy and allow privacy for residents at any time. Bedrooms are of a size that allow appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. Where a resident does not have their own phone connection, there is a mobile telephone that residents can take to their rooms, enabling residents to have privacy when making phone calls. There are locks on all toilet and bathroom doors and staff always knock on residents’ doors prior to entering. The nurses’ stations provides privacy of stored information. Privacy when discussions concerning residents take place is in residents' rooms. Staff education on privacy takes place at orientation, and during in-service education (next due in November 2014), as staff interviews and staff files.Care plans identify residents like and dislikes and interventions identify the assistance the resident requires to meet their needs. Residents are encouraged by staff to be as active as is safely possible. Residents are addressed in a respectful manner and by their preferred names (confirmed by observation and in interviews) Residents are assisted to maintain dignity and respect and to ensure the residents' sexuality and intimacy needs are both supported and protected, while protecting the wellbeing of others. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure residents receive services that respect their individual values and beliefs. Staff demonstrate an awareness of the need to provide a service that is responsive to these needs. Residents and families receive clinical services that have regard for their dignity, privacy and independence.Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The individual employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. As confirmed by staff interviews, all staff said they would report anything of concern to management. Interviews with residents and families confirm they have no concerns related to abuse or neglect. All comments highly praise the care provided by Eileen Mary. Education on abuse and neglect was presented in March 2014, Cultural Awareness training occurred in January 2014. Skin management and pressure area training is due in July 2014 and Rights, Advocacy, Independence and Individuality training is due in November 2014. Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives. Evidence of this is sighted in files ( five of five rest home and four of four hospital) reviewed. Resident, family and staff interviews confirm services implemented ensures residents are treated with respect and care is delivered in a manner that has regard for the resident’s privacy, independence, dignity and respect.During interview there are comments made highly praising the care provided by Eileen Mary. In regard to the laundry, all residents commented positively on the care taken by Eileen Mary towards their clothing. “All clothes are ironed nicely and woollens hand washed to ensure the presentation of the residents is of a high standard”. The ARRC requirements are met |

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

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

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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 1.1.3.2 (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:** |
| There is a detailed Maori health policy and procedure. The purpose of this policy is to ensure that services provided are culturally sensitive, recognize Maori protocols, values and beliefs, and are seen to be appropriate by Maori residents, staff and their whanau. The procedures include definitions and a description of the Te Whare Tapa Wha model of health. Eileen Mary will consult with residents who identify as Maori and their whanau to ensure that their cultural values and beliefs are incorporated into the care and support they receive. There are no residents at Eileen Mary who identify as Maori however Eileen Mary recognizes the special relationship between Iwi and the Crown and appreciate that the principles of The Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing.There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organizations model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. Local Maori health providers support the facility and present education (presented in January 2014) and advise related to cultural safety. The requirements of the ARRC 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:** |
| Eileen Mary provides an environment that enables residents to receive culturally safe services that recognize and respect individual ethnic, cultural and spiritual values and beliefs. Eileen Mary has a Cultural safety policy and procedure which sets out the intention for all staff will to be able to recognize and respect the culture, values and beliefs of our residents, their families and our colleagues. Yearly in-service training is provided on cultural safety and the Treaty. The admission and ongoing assessment process identifies and documents the resident's specific cultural and spiritual needs, values and beliefs and informs the care planning and activity planning process to ensure that specific residents’ needs and objectives are met. Residents and/or family/whanau or their nominated representative are consulted about individual values and beliefs to ascertain if there are any special requirements needed to be met by the service. Evidence of this is sighted in files reviewed and resident, family and staff interviews. A multi-denominational roster of church service is sighted in the activities program. Other requests can be arranged with management and some resident’s families access their own spiritual support from the community. Open visiting policy allows family/whanau to visit when they are able. The ARRC requirements are met. |

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

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

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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:** |
| Eileen Mary provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively and residents are kept up to date as verified by resident and family interviews.Orientation/induction processes inform staff on the Code, the house rules and the code of conduct. The staff job descriptions, employment agreement, company policies and house rules provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries. Staff are unable to accept gifts from residents. A signature acknowledging the terms related to all this information is located in all employment agreements, as evidenced in staff files. Staff interviews verify knowledge of the discrimination policy. The facility manager will action formal disciplinary procedure if there is an employee breach of conduct.The ARRC requirements are met. |

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

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

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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:** |
| Eileen Mary provides an environment that encourages good practice. All policies sighted are up to date and relevant reference is made to related sources, legislation and the Health and Disability Services Standards requirements. They are reflective of evidence based practices, which are monitored and evaluated at organisational and facility level.New employees complete a comprehensive orientation/induction programme that is relevant to the role they undertake. The service supports and encourages staff with appropriate on-going education relevant to their role. The service has an in-service education programme in place which is monitored to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. All care staff have or are undertaking the National Certificate in Support of the Older Person, provided onsite by the facility assessor. All staff who administer medication have yearly assessments to determine competency (three of three competencies sighted). All staff have up to date training in CPR and choking (sighted). Enrolled nurses, RNs and Team Leaders have an up to date First Aid certificates. Registered nurse education is supported by MidCentral District Health Board (MDHB), the specialist services that they operate and the local Hospice services (training records sighted) The diversional therapist, has a recognised diversional therapy training, and liaises with other diversional therapists to up skill, review, assess, evaluate and support each other in fulfilling residents’ needs and aspirations. Cooks and kitchen staff have training in food safety (certificates sighted). All five of five, laundry and cleaning staff have completed an appropriate training programme (sighted and verified by five of five interviews with cleaning and laundry staff). Staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner. Resident and family interviews verify satisfaction with the services provided. Residents comment on how ‘wonderful’ the staff are and how they go out of their way to help the residents’ feel at home and comfortable.Interview with the GP, verifies he is happy with the ”meticulous services provided by Eileen Mary”. The service responds promptly and correctly to his requests and is prompt in requesting his input if needed.The ARRC requirements are met. |

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

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

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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:** |
| Eileen Mary provides an environment conducive to effective communication. An open disclosure policy provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Clinical staff interviewed (three from the hospital and four from the rest home) confirm they understand that relatives and residents must be informed of any changes in care provision. There are no residents that require interpreting services; however, the facility manager, administration staff and clinical staff are aware of how to access interpreters if this service should be required.Staff are identifiable by their name badge and uniforms and introduce themselves to residents upon entering the resident's room (observed).Evidence of open disclosure is sighted on incident and accident forms and on the family communication record sheet in five of five rest home and four of four hospital resident's files reviewed. Residents and family confirm communication with staff is open and effective, they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews as verified by resident and family interviews. The ARRC requirements are met |

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

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

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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:** |
|  Eileen Mary has a well-developed policy and procedure on informed consents and provides residents and where appropriate their family/whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided. Residents are able to choose their GP of choice. The FM and RN discusses information on informed consent with the resident and family / whanau on admission. Consents request the resident's agreement to; collect and retain information, for a photograph for identification purposes, a name on a bedroom door and to travel in transport organized. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process. Files reviewed evidence informed consent forms signed on admission, medication charts (18 of 18) have residents’ photographs for identification. Documentation identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. The resident and family interviews indicate satisfaction with involvement in care.An advance directive enables a competent resident to choose if they would or would not like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non-consent to be revoked at any time. Advance directives are sighted in files reviewed. Verbal consent is obtained prior to an intervention being carried out as confirmed in resident and family interview and observed at audit. Staff education on consent takes place during orientation and in-service education (yearly in November). Staff have an understanding of the informed consent process and the resident's right to: privacy, to be treated with respect and dignity, to make choices, change their mind and to be fully informed of all care procedures (confirmed in interviews). Examples are sighted related to respecting residents' wishes: to attend chapel weekly; food likes and dislikes being catered for; activities in the activities program and individual’s involvement are at the resident's request; and an environment where choices are openly acknowledged and offered. Resident and family interviews confirm resident choices are respected by staff. The ARRC requirements are met |

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

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

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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:** |
| Eileen Mary recognises and facilitates the right of residents to advocacy/support persons of their choice. The Resident Right's Policy identifies the resident's right to access an independent advocate and their right to have a support person of their choice. Residents are informed of their right to advocacy services during their admission and advised of their right to contact the Health and Disability Commissioner’s office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is available in brochure format at the entrance to the facility and is included in the admission information. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons, as verified in resident and family interviews.Staff demonstrate appropriate knowledge related to the resident's right to have an advocate or support person of choice at any time, as verified by four of four care staff, one of one facility manager, one of one enrolled nurse and two of two RN’s interviews.The diversional therapist runs the monthly residents' meetings and when areas are identified as needing to be addressed, will initiate actions to enable a solution to be put in place. An interview with the visiting chaplain states she “will be a resident advocate if the resident requests it of her”. The ARRC requirements are met. |

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

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

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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:** |
| Stage one: a number of the policies sited in the previous standards include an emphasis on family /whanau involvement and engaging with family members. Eileen Mary provides an environment whereby residents are able to maintain links with family/whanau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges, values and encourages the involvement of families/whanau in the provision of care and the activities programme actively supports community involvement and accesses community resources. Eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau confirm that visitors can visit freely and there is free access to community services. It was observed that there were visitors coming and going from the facility during the audit. File reviews, facility manager and the diversional therapist confirms community services used by the facility include:- local social groups, - the local community centre activities- other aged care facilities- local church groups and services- the MidCentral Health DHB nurse specialists- Support links (the local needs assessment and service coordination agency) (NASC) - the service has a podiatrist who visits six weekly and a physiotherapist who visits weekly.- residents have the GP of their choice whom visits or the resident goes to.- MidCentral Health outpatient and inpatient services as appropriate.The ARRC requirements are met  |

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

Consumers have access to visitors of their choice.

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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:** |
| Stage one: There is a detailed Complaint policy and procedure which meets the requirements of this standard. Staff are trained in the policy at orientation, at their three month orientation review and at annual performance appraisal. Residents and their family/whanau are informed of the policy and their right to make a complaint on entry to the service. The policy is included in the entry pack given to all residents / family / whanau. The complaints policy is cross-referenced with the Open disclosure policy. This includes the statement: “Families, residents and staff are kept well informed of all relevant issues regarding Eileen Mary and when it specifically involves themselves or their loved one. There is an overarching principle of hiding nothing and working together to resolve any disconnect between expectation and care received.” Stage two: Interviews with the GM and FM confirm that the organisation’s policy and procedure are implemented. Both managers demonstrate an understanding of the requirements of the Code, their own procedures and the importance of complaints as a method of receiving feedback which enables them to improve services. There are two levels of complaints, with some being categorized as ‘minor complaints’ which are addressed immediately. Evidence reviewed indicates that all issues, concerns and complaints raised by residents or family/whanau are addressed appropriately and in an open and transparent manner. Eileen Mary uses a Service Feedback Form for the reporting of complaints and compliments. A register is maintained of all complaints and associated records and correspondence. Complaint data is incorporated into the FM’s monthly reports to the GM and all significant complaints are reported to the Director when they occur. One significant complaint was received on 5 November 2013 and was acknowledged by both the FM and the GM. In addition to written correspondence a full investigation was conducted, staff members involved were interviewed as well as the resident’s GP. A comprehensive response to the family was sent and they were included in the investigation. The family, and resident, accepted the facility’s response and addressing of the issues raised. This family were one of the respondents to the recent satisfaction survey and their responses are complimentary and positive. A register is maintained which records all complaints and the actions taken to address them. This process allows for the time frames of the Code to be met. ARC 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:** |
| Stage one: There is a vision and philosophy policy and procedure document. The vision is: Eileen Mary will be an established centre of excellence for aged residential care. The philosophy is: Optimum care delivered in a safe and supportive environment. The document was last reviewed in March 2014 and will be reviewed again in 2017, in line with the organisation’s document management system. Staff members are informed of the organisation’s purpose, values, scope, direction and goals through the vision and philosophy document. This is included in the pre-employment pack given to all newly appointed staff members. It is discussed through their orientation and is referred and incorporated into communication to staff, families and residents. Stage two: The facility manager (FM) at Eileen Mary is a registered nurse (RN) who has worked in acute cardiothoracic and coronary care overseas before coming to New Zealand six years ago. Since then she has worked at Eileen Mary as a RN before being appointed to the role of FM in December 2012. She has a current annual practicing certificate and has attended relevant training to maintain the currency of her skills. The general manager (GM) mentored and coached her as a new manager when she was first appointed to the position. At interview with the FM she is able to clearly articulate her responsibilities as the manager and her reporting requirements. She provides a detailed monthly report to the GM each month. The GM discusses this with the owner so that he is aware of day to day progress at the facility and can be brought into any operational management issues when required. The FM position description clearly describes the responsibilities and accountabilities of the role. Her position differs from that of the previous FM as she is also the clinical nurse leader for Eileen Mary. Records and files reviewed on site demonstrate that she is performing all the requirements of her position. ARC 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:** CI |
| **Evidence:** |
| The FM is responsible for the clinical leadership of the facility as well as day to day management and operations. There is oversight from the GM, who is based in the ‘sister’ facility in Fielding. The Eileen Mary management team is made up of the FM and an office manager (OM) who provides administrative support to the FM as well as being responsible for administrative systems of the facility. The GM reports at interview that the FM has made the transition from RN to FM effectively and that she is respected by staff. A recent (April 2014) resident and family satisfaction survey demonstrates a 96% strongly agree or agree that the service is well managed. Other aspects of the survey (clinical and medical services, house-keeping, food, diversional therapy, and laundry) range between 88% and 99% satisfaction. A range of residents, family members, external health professionals and Eileen Mary staff members were interviewed and report a similarly high level of satisfaction with the service and the way it is managed.In a temporary absence of the FM several initiatives are put in place. The GM increases the frequency of her visits. (She is also available to contact by phone when she is at the other facility.) The office manager (OM) has oversight of the house-keeping (cleaning and laundry) and food services. One RN on each shift is identified as the lead staff member who will undertake the management role if needed. The FM will go on six months parental leave at the beginning of June (returning in early December). During this absence a more formal arrangement to cover the FM role is planned. This includes the GM visiting and working in the facility for two days a week. An experienced RN will take on the FM role for the other three days of the working week. Over weekends and evenings the existing arrangements apply. A continuous improvement rating is identified against this standard. The service achieves beyond full attainment of this standard. The GM completed a service delivery restructure in August 2012 and developed a plan to improve service delivery through changes in the staff structure and the delivery of care. The current facility manager was appointed to the role in December 2012, and, working with the GM, the changes to the staff structure and model of care were implemented. In preparation for the facility’s recertification audit, and with the results of the April 2014 satisfaction survey, the GM reviewed the changes made to the management of the service. This is documented in a written report provided to the audit team during the onsite audit. The customer satisfaction survey is divided into a number of different areas, including clinical, medical, food, laundry and house-keeping services, and safety and security all rate in the mid-90th percentage. Diversional therapy and administration rate in the high 80 percentage. The overall result from the survey is a 96% satisfaction rate. At interview with a wide range of staff (12) there is a consistent message of clear communication from the management team, improvement in the way the facility is managed and increased satisfaction by staff members. One of the 12 staff members interviewed commented that the from the interview stage through to their orientation the process has been very professional and well planned. Interviews with a range of family members and residents provide a clear message of satisfaction with individual staff and the service as a whole.  |

##### **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:** |
| Stage one: There is a Guide to risk management and risk management planning and a Quality Improvement policy. The organisation’s risk management processes are based on the Australian and New Zealand Standard on Risk management and includes the risk management framework / flowchart which includes the steps to identify, analyse, evaluate and treat risks. The Quality improvement policy and procedure outlines Eileen Mary’s philosophy of quality and the procedures in place to monitor performance, measure outputs and to determine whether corrective actions or quality improvement projects are required. The policy statement places residents centrally in the organisation’s quality activities so that they are listened to and the organisation is proactive in responding to issues which requirement improvement.Stage two: The quality improvement policy is implemented and guides the reporting and recording of exceptions, collation and analysis of data and reporting to staff members and the GM and owner through the FM’s monthly reports. A selection of monthly reports were reviewed in detail, from the available reports since January 2013 when the current FM commenced in her role. All include reporting and analysis of events as required by the quality improvement policy and the way these are managed and responded to. Similarly the requirements for sharing information with staff members, and residents and family/whanau when appropriate, are met. Review of the range of staff meeting minutes (all staff bi-monthly and by function across the facility on a bi-monthly or six weekly cycle) confirms that these are consistently held. Minutes are of a high standard and record detailed information about discussions, input and feedback and noting progress on implementing new initiatives, quality improvements and projects. Document management is the responsibility of the GM. There is one hard copy of the organisation’s policies and procedures, available to staff in the nurses’ station. This is maintained by the OM who prints off any new or updated documents and removes the obsolete version from the manual. Staff who have computer access are also able to review policies and procedures electronically. Only the current versions of documents are available to staff. The policies and procedures reviewed are all current and have been reviewed in the timeframe required by the organisation. This varies from annually for some documents to three yearly for others. Any document can be reviewed more frequently than its designated date if needed. Policies are reviewed by the FM, GM, other staff members with relevant experience and knowledge. A previous staff member who has a Masters and a PhD in nursing of older people, works on contract on specific projects which includes review of the organisation’s systems and documents. Documents are well written and concise. All accidents, incidents, infections, medication errors, complaints, and the use of restraints and enablers are monitored by the facility. Data is collated by the OM and the FM. Data is reported to the GM in the FM’s monthly reports; to staff members at the bi-monthly (all) staff meetings; to nurses and caregivers at their six weekly meetings and to house-keeping, laundry and food services staff at their respective bi-monthly meetings. A range of 12 staff members were interviewed during the onsite audit. These include the maintenance person, one of the laundry staff, two of the cleaning staff including the team leader, two of the kitchen staff including the cook, four care givers and two RNs. The three management team members were also interviewed. Interviews with these staff confirm that collated data is reported to them and discussed at the range of different meetings. They are also able to review graphed data provided with meetings and available with meeting minutes after each meeting occurs. If staff members are not able to attend a meeting, copies of the minutes are available in the staff room until everyone has reviewed them and then filed with the staff signing sheet. Eileen Mary does not have function specific committees (ie: health and safety, infection control, quality). Staff members have assigned responsibilities and all receive information, including collated data, and are involved in analysing results in the range of meetings. The FM leads discussions at the staff meetings and provides all data so that staff are able to understand any corrective actions, changes to procedures and / or quality improvement initiatives when they are implemented. Review of staff meetings minutes confirms that they occur as scheduled, and there is transparency of data. Corrective action plans are included on all event reporting forms, on the Service Improvement Feedback form used for complaints and compliments and on the Quality Improvement Project form. Plans are developed in response to individual events on the event report form when appropriate, or, if a trend or systemic issues identified using the quality improvement project form and process. A review of the Accident / Incident Monitoring (AIM) folder demonstrates that there is a good level of reporting by staff and analysis by the facility manager. A range of quality improvement projects have been identified and these come from trends identified in AIM reports and based on feedback from residents, family/whanau and staff members. At interview the GM and FM report that the monthly reports from the FM and their frequent meetings and discussions enables monitoring of progress against the organisation’s quality and risk management systems. Staff members interviewed (12) and the OM confirm that information is shared, there is open reporting and management of events and staff members have sufficient information to know what is happening and their role and responsibilities in managing quality and risks. As with the quality improvement process, the risks identified in the risk management plan are monitored through the FM’s monthly reports and annual review by the GM. The current risk management plan was developed in July 2013 and will be reviewed at the end of July 2014.  |

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

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

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

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

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

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| **Attainment and Risk:** 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:** |
| Stage one: There is an incident accident policy and procedure which provides a process for reporting of events and definitions of incidents and accidents. There is a specific AIM (accident / incident monitoring) form which is used to report any event. The procedure part of the document has a heading ‘incident, accident and hazards’. All incidents / accidents are to be reported during the shift on which they occur. Staff are trained in incident / accident reporting at orientation and there is on-going training as part of the in-service training calendar. There is information about essential reporting and notification in the infection control procedures and the staff health and safety policy and procedure. Stage two: AIM reports, service improvements (complaints and compliments), infections, medication errors are all reported using the organisation’s forms and processes for reporting. The FM monitors all events which occur and ensures that appropriate follow-up action is taken. When needed, events are escalated to the GM and the Director. The OM enters all event data onto the AIM / infection / medication error or complaint database. This allows for analysis of all data as well as analysis over time and identification of trends. Staff meeting minutes all include regular reporting of event data by the FM to all staff members. This data is included in her monthly report to the GM and at interview both the GM and OM confirm that they review her reports and event data on each visit to the facility. Staff and managers interviewed (12 and three respectively) confirm that they are informed of event data, corrective action plans and progress in addressing trends or systemic issues.  |

##### **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:** FA |
| **Evidence:** |
| Stage one: There are a range of human resource policies and procedures which provide guidance in the recruiting, selecting and appointing new staff members; and for orientation and induction of all staff. These processes meet the requirements of good employment practices and this standard. Appointment of new staff includes appropriate reference and police checking. All new staff will have a preceptor or mentor appointed to guide them through the induction / orientation process. An orientation checklist is used to record the progress and completion of the orientation. Performance appraisals are completed at the end of the first 2 - 3 months after appointment and then annually during their anniversary month. There is a Staff Health and Safety policy and procedure which describes a range of activities and responsibilities of staff members , the management team. These activities are designed to ensure both a safe workplace and a safe place for residents, and their family/whanau/visitors. Stage two: Nine personnel files were reviewed during the onsite audit. These are the FM’s and OM’s files, and those of two care givers, two RNs, house-keeping staff and the maintenance person. These demonstrate that the organisation’s human resource processes are implemented. All files confirm that the procedures in place at the time of the individual’s appointment were followed. (A number of staff members have worked at Eileen Mary for more than 10 years.) Recruitment and appointment includes validation of professional registrations, where relevant, and a record of registration and practicing certificates also. Staff members interviewed confirm that they receive an effective induction and orientation to Eileen Mary. The formal orientation is confirmed through use of a checklist and all staff members files who have completed this programme have a completed checklist. The facility has an enrolled nurse (EN) who is their caregiver training coordinator one day a week and an EN working on the floor four days a week. She is responsible for the orientation of all new caregiving staff and was interviewed during the onsite audit. Other staff members’ orientation is managed by either the FM or the person’s immediate supervisor. Staff members interviewed comment that they found the orientation very effective and professional. There is a comprehensive programme of ongoing ‘in-service’ training which is scheduled at least once a month. Training is delivered by appropriate staff of the facility (eg, the GM delivers the AIM and event reporting training, the FM delivers the restraint minimization training, or by an external specialist (eg, the representative from Superclean which provides their cleaning and laundry products, the Safe manual handling and use of hoists is delivery by the representative from the company which supplied the hoists)). The facility supports all RNs and the EN to maintain their professional development requirements and caregivers are supported to commence Careerforce qualifications within six months of commencing work. The EN / training coordinator provides assistance and coaching to all caregivers to support them to complete their qualification. The facility’s diversional therapist has completed the National Certificate in Diversional therapy (completed in 2009) and is a member of the local Diversional Therapist’s Association.  |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: There is a policy – Clinical Duty Roster – which outlines the process for rostering staff at safe levels and the appropriate mix of staff members (ie, care givers / RNs / house-keeping / kitchen staff members). The policy includes the safe staffing statement: “There are Registered Nurses, Enrolled Nurses and Qualified Caregivers at Eileen Mary Aged Care. The rosters are compiled ensuring there is the correct skill mix for each shift. Safety is paramount to the management of Eileen Mary Aged Care Ltd and every endeavor will be made to ensure there are safe staffing levels at all times.”Stage two: Eileen Mary has moved to a four on / two off roster. This has been in place since early 2014 and has improved staff members satisfaction with the allocation of shifts and in their perception of their ability to provide a high level of care to residents at all times, as sighted in staff meeting minutes across February – May 2014. The clinical services section of the April 2014 satisfaction survey (residents and families) received a 92% satisfaction rating. This area of the survey includes questions about staffing, service management as well as the standard of care.The current roster was reviewed on site with the GM and FM. It provides for staffing levels to those required for hospital care to incorporate the ability of the facility to provide either hospital or rest home care in all 58 beds. On each morning shift there is a RN and eight care staff (caregivers and health care assistants). On each afternoon shift there is one RN and six care staff, and overnight there is one RN and two care staff Monday to Sunday. The RN is always the team lead on the high acuity wing of the facility. On the low acuity wing the team leader is either the enrolled nurse or one of the health care assistants. There is a laundry team member and two cleaning team members on each morning shift, Monday – Sunday. There are two kitchen team members working 5am to 2.30pm, and one each afternoon, Monday – Sunday. The FM is an additional RN resource in the facility, Monday – Friday, 8am to 5pm, and available on call outside these hours.All residents and family members interviewed report that they believe there are adequate numbers of staff available across all shifts. At interview with a range of staff members (12) they also report that staffing levels allow for the provision of safe care.  |

##### **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:** |
| Residents admitted to Eileen Mary have the information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission (verified by five of five rest home and four of four rest home resident files reviewed). The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded. All records sighted are secure. Archived files are in a locked room, and easily accessible. Resident information is kept in hard copy format. The registered nurse takes responsibility for resident file content. The service is not responsible for NHI numbers. The service receives referral information from Support Links (local NASC) which includes relevant assessment and medical information. This information is used to develop individual files.The administrator keeps a register of past and present residents which includes details of name, NHI, date of birth (DOB), GP and room number plus admission date and address, next of kin ( NOK) and date left service (including discharge address) and or deceased. This is then saved and referenced to notes archived. All relevant ARRC requirements are met. |

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

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

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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:** |
| Eileen Mary provides an environment whereby, when the need for service has been identified, it is able to provide a planned, co-ordinated service that is delivered in a timely and appropriate manner.Access and entry criteria and service availability is documented and communicated to residents and their family/whanau by local doctors, referral agencies, MDHB, Anglican care and local community groups. Documentation includes information about the services provided, its location, hours, how service is accessed, residents’ rights and responsibilities including a copy of the Code, the availability of cultural support, after hours or emergency contacts if needed and identifies the process if a resident requires a change in the care provided. If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency (Support Links). All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents when they call in. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Facility Manager or RN.Resident and family members interviewed confirm when the need for care was initially identified it was delivered in a planned, timely and appropriate manner. Admission agreements (nine of nine) are sighted and meet contractual requirements.The ARRC 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:** |
| Eileen Mary has a clear process for informing residents, their family / whanau and their referrers if entry is declined. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Declining in the past has been due to Eileen Mary not offering the service required as identified in the Support Links assessment. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services. The reason for declining entry are documented and kept on file. The admission agreement (sighted), describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility. The ARRC 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:** |
| Policies and procedures that meet Health and Disability Services Standards (HDSS) and the Age Related Residential Care Contract (ARRC) guide the provision of services at Eileen Mary. On admission, an initial assessment, including information from the resident, their nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services is gathered and documented by the RN within 24 hours of admission. Medical assessment is conducted prior to admission by the general practitioner (GP) or the doctor at MDHB or within 24 hours of admission, and the treatment program required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.Within three weeks of admission the RN completes a long term care plan, based on the collection of more detailed assessment data. The long term care plan directs the care required to meet the resident’s need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift. The assessment, care plan and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met. Family contact is documented in the family contact record. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable and this is documented by the GP. Evidence of this is sighted in files reviewed and verified by resident and family interviews. RN practicing certificates, medication competencies and first aid certificates are sighted plus one of one enrolled nurses practicing certificate. Caregivers with experience, education and training in National Certificate in Support of the Older Person (as evidenced by training records) provide most of the direct provision of care. The registered nurse acts as the resident’s case manager and is responsible for planning, reviewing and overseeing all aspects of the resident’s care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cook and kitchen assistants have training in food safety and hygiene. The contracted physiotherapist and podiatrist provide services to the residents. The annual practicing certificates (APCs) are sighted for all other staff and contracted staff that require an APC. The diversional therapist has appropriate training and evidence of this is sighted. Health professionals delivering the daily care to residents, write in the resident's progress notes at the end of each shift. Allocated caregivers are the residents’ key workers. A verbal handover by the registered nurse occurs at the beginning of each shift to ensure all staff is familiar with the resident needs. Resident notes are integrated and demonstrate input from a variety of health professionals and is responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in five of five residents’ files, where specialist input is required. The ARRC contract requirements are met.Tracer 1 – Rest Home - A rest home resident is reviewed using Tracer Methodology *XXXXXX This information has been deleted as it is specific to the health care of a resident*Tracer 2 – Hospital - A hospital resident is reviewed using Tracer Methodology. *XXXXXX This information has been deleted as it is specific to the health care of a resident* |

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

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

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

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

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

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

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

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

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

#### Standard 1.3.4: 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:** |
| Residents' have their needs identified through a variety of information sources that includes the assessment by Support Links, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered informs the care planning process. Within 24 hours of admission an initial assessment is undertaken by the RN to identify immediate need and plan the care required to meet these. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested. Over the next three weeks, the RN undertakes more comprehensive assessments. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care and activity planning. The assessments are reviewed six monthly or as needs, outcomes and goals of the resident changeA medical assessment is undertaken prior to or within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. Evidence of this is sighted in five of five rest home and four of four hospital files reviewed. Interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau, verify they are included in and informed of all assessment findings, updates and changes. Seven of seven care staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs. The ARRC requirements are met.  |

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

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

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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:** FA |
| **Evidence:** |
| The care plan developed in consultation with the resident and/or family/whanau, documents the plan of care identified by initial and on-going individual assessments, and identifies appropriate resident guided interventions to enable the resident to meet their need, goal and desired outcome.Residents have one set of clinical notes in which all providers involved with the resident’s care use to document the resident’s progress. Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care providers. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book and the resident's care plan.Care plans are evaluated six monthly or more frequent as the resident's condition dictates. Short term care plans, document the existence of short term problems and the required intervention.Information from the assessment process informs the allied services of residents’ need. The kitchen is informed of need regarding nutrition, activity assessments inform the diversional therapist of interventions required in the activities programme.Evidence of this is sighted in five of five rest home and four of four hospital files reviewed. Interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital residents family/whanau, verify they are included in the planning of their care. The staff education records sighted for nine of nine staff demonstrate that staff receive appropriate training. Training records evidence education that includes skin management, falls prevention, spirituality, nutrition and hygiene, infection control, rights and advocacy, wound care, restraint minimization and safe practice and elder abuse and neglect. The RNs participate in the Professional Development Recognition Programme at MidCentral DHB.Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit.The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced proceduresThe ARRC requirements are met. |

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

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

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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 1.3.5.3 (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:** |
| Stage one: A range of clinical / support policies and procedures were provided at document review. These are: Activities for daily living, Wound care guidelines, Death and dying, Elimination, Fall management, Management of Challenging behaviours, Pain management, Resuscitation, Transportation of residents, Sexuality and intimacy. Stage one: A range of clinical/support policies and procedures were provided at document review. These are: Activities for daily living, Wound care guidelines, Death and dying, Elimination, Fall management, Management of Challenging behaviours, Pain management, Resuscitation, Transportation of residents, Sexuality and intimacy.The care and services at Eileen Mary are delivered in a safe and respectful manner. New residents are welcomed and orientated to the facility (confirmed at interview with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau). The care plan documents the care the resident requires to meet the resident’s assessed needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards.The provision of care is consistent with the desired outcomes in all five of five rest home residents and four of four hospital residents’ files reviewed which document the residents’ physical, social, spiritual and emotional needs and desired outcomes.Interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau expressed satisfaction with the admission process, the care, the respect shown to them and the quality of the food that they or their relative receives.There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident’s needs (sighted).The residents use their GP of choice who either visits Eileen Mary or at times residents attend the GP practice.Appropriate links with other services are maintained. The MidCentral DHB clinical nurse specialists and hospice nurses are available for advice, consultation and review. There is evidence of referrals to specialist services and specialists input in resident's files. A physiotherapist visits weekly and a podiatrist visits six monthly. The RN interviewed describes the transfer procedure and explains that resident’s care plans summary and medication charts are photocopied and accompany the resident when transferred. The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Eileen Mary employs the services of a trained Diversional Therapist (DT) five days per week and a diversional therapy assistant two days a week. On admission, residents are assessed by the DT to ascertain their needs and appropriate activity requirements. The activities assessments and plans’ include the resident’s preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.Activities reflect ordinary patterns of life and include normal community activities (eg, bus and train outings, visiting entertainers, visits to other facilities, outings to community events, visits from community groups, church services and home visits). Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the resident’s response to the activities, level of interest and participation recorded, as sighted in eight of eight files reviewed. The goals are developed with the resident and their family, where appropriate.A residents meeting is held every six weeks by the DT and meeting minutes evidence that the activities programme is discussed and residents requests are being actioned. The yearly resident/relative satisfaction survey also captures feedback on the activities programme, as does ‘satisfaction with activity surveys’. Residents and family are satisfied with the activities offered as verified by interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau.The DT is supported in her role by the diversional therapy networks in the region and she attends diversional therapy workshops and conferences. The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.Care plan evaluation is undertaken six monthly or as needs change to measure the degree of achievement or response of each resident related to their goals. Where progress is different from expected, the service initiates changes to the care plan. A short term care plan is initiated for issues such as infections, wound care, changes in mobility and the resident’s general condition. The RN undertakes and documents all care plan evaluations with the resident and/or family/whanau, at least every six months. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.Evidence of evaluation is sighted in five of five rest home and three of three hospital files reviewed. Interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau verify they are included and informed of all care plan updates and changes.The ARRC requirements are met.  |

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

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

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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:** |
| Resident support for access or referral to other health and/or disability service providers is facilitated to meet the residents need. If the need for other non-urgent services are indicated or requested, the GP or FM sends a referral to seek specialist service provider assistance from the MidCentral DHB. Referrals are followed up on a regular basis by the facility manager or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, though where possible a family member accompanies the resident. The facility has a van that can escort residents to appointments. The resident's family will be notified of the upcoming appointment and will be invited to attend and assist, unless the resident requests otherwise.Acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed. The ARRC requirements are met |

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

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

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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:** |
| Exit, discharge or transfer is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person / facility responsible for the ongoing management of the resident. There is a specific transfer/discharge form, that records all the relative information needed when transferring a resident. If the resident is transferring to the MidCentral DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes. The ARRC requirements are met. |

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

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

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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:** FA |
| **Evidence:** |
| Stage one: Eileen Mary has a detailed Medication management policy and procedure. All medications are administered by RNs, ENS or Team Leaders who are deemed medication competent, to ensure safety and the highest standards. The Medication Management Policy at Eileen Mary is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. Medicines for residents are received from the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All staff who administer medicines have current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management. Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range The medicine prescription is signed individually by the GP. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. Medicine charts (eight of eight hospital and ten of ten rest home) reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart. The initial and ongoing assessments of three of three residents who self-administer medication is sighted and fulfils the facility’s policy that ensures a safe process for drug self-administration. Any medication errors that occur are reported to the FM are recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. The FM reports three recent medication incidents that relate to medication being found on the floor in the dining room. Incident forms are sighted and identified action plans are in place.The facility manager ensures all staff who administer medications have current competencies. Enrolled nurses and RNs are assessed for medication competency yearly and approved senior caregivers (team leaders in the rest home) are certified as competent in Medication Administration (documentation sighted), under the direction and delegation of a RN.Standing orders are not used at Eileen Mary. Evidence of drug reconciliation is sighted.The ARRC requirements are met |

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

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

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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 1.3.12.3 (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:** |
| Stage one: There is a 33 page Food Services policy. This covers a wide range of issues relating to food and nutrition including the facility’s intention that all residents have well prepared, well cooked, well presented and nutritious food and meals. There will be well designed menus which provide a balanced diet, and kitchen will be well maintained, hygienic and safe. Residents’ nutrition needs are assessed on entry to the service. The menus will be assessed annually by a registered dietician. Staff responsible for food preparation and /or storage will receive regular training. Residents with special dietary needs will have an individualised dietary plan. There are summer and winter menus which are cycled so that there is minimal repetition and a wide variety of meals / dishes provided. Snacks are provided at morning tea / afternoon / supper and as requested by residents. There are guidelines for providing meals / food to residents who have special / modified diets, are unwell, need to increase or decrease their weight for reason, and special occasions are catered for in menu planning. There are identified celebration days (14) which include Christmas Day, Easter Friday and Sunday, Queen’s birthday, Guy Fawkes day, Waitangi Day the region’s anniversary, in addition to each resident’s birthday. There are detailed instructions and guidelines for the operation of the kitchen which includes: ordering of supplies, storage, organisation of the pantry, fridge and freezer. Food services are included in the facility’s quality improvement activities. The planned menu at Eileen Mary which changes seasonally (sighted) is reviewed by the dietician March-2014. The nutritional requirements are based on the Ministry of Health (MOH) food and nutritional guidelines for older people. The facility has policies and procedures relating to food and nutrition services in place that are reviewed at least two yearly (sighted).Training records verify the cook and kitchen staff is trained in safe food handling and this is verified by interviews with one of one cook and one of one kitchen hand. The facility provides annual training in nutrition and food related aspects of resident care for kitchen staff, registered nurses and care givers (due July 2014) and the dietician recently presented an in service on managing a hypoglycaemic event in residents who have diabetes, as sighted in training records and verified through interviews with seven of seven care staff and two of two kitchen staff. Superclean monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. There is evidence to support sufficient food is ordered and prepared to meet the resident’s needs and recommended nutritional requirements (cooked meat, chicken or fish and fresh fruit 100gm/ day). Evidence of resident satisfaction with meals is verified by interviews with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau, sighted satisfaction surveys, feedback at meal times and resident meeting minutes.There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed, (sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience.All food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered three times per week. Meats and fish are ordered twice weekly. When food is delivered it is checked for ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. A cleaning schedule is sighted, that details a weekly schedule of cleaning responsibilities. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed . Dietary profiles are retained in the kitchen and recorded on a white board for easy observation.The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

#### Standard 1.4.1: 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:** |
| Stage one: The Waste management policy covers general household waste and rubbish, and includes provisions for recycling. The policy statement indicates that staff will be trained in the disposal of waste in line with infection prevention and control guidelines. Part seven of the Infection control programme for facility is ‘maintaining a safe environment’. This covers cleaning services and duties, cleaning methods and products used (ie, detergent and disinfectant, rather than specific named products.) Laundry services includes sluicing of items and management of waste on laundry items and linen, and soiled items and linen. Hazardous spills are also included, as are management of sharps, body fluid, and preventing pests. Stage two: Cleaning and laundry protocols, and guidance in the use of specific cleaning and laundry products, are on display in the laundry, sluice rooms (two) and in the treatment room. The cleaning and laundry staff members interviewed (two) report that they have access to information and training about the appropriate management of waste and hazardous substances. Observed during the onsite audit are staff members using equipment and handling soiled items in line with the organisation’s procedures. Personal protective equipment is available in the laundry and sluice rooms and in other locations throughout the facility. Staff are observed using such equipment when appropriate. Cleaning products and solutions are in original labelled containers and are stored securely when not in use. ARC contract requirements are met. |

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

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

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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:** |
| There is a current building warrant of fitness (BWOF) for the Eileen Mary facility. This was issued on 12 May 2014 and expires on 13 May 2015. The facility has been designed to meet the needs of older people who are receiving rest home and hospital level. All floor surfaces, furnishings and decorations are appropriate and fit for purpose. All are in good working order, well maintained and the environment is clean and hygienic. Handrails are installed throughout the facility and doorways, entrances and exits all promote safety and ease of access. During the audit residents are observed moving about the facility either independently, using mobility equipment or with assistance from staff or family members. The whole environment is well maintained with appealing furnishings and décor. It is suitable for residents and visitors and promotes wellbeing. The facility is constructed on a flat site with level entrances and exits. There is a large central courtyard / garden which is paved and has lawn areas. There is level access throughout all external areas so that both independence and safety are promoted. Staff health and safety guidelines direct the notification of hazards through the AIM reporting system and ensuring they maintain a safe workplace for residents and staff members. Hazard reports are noted in the review of the AIM folder with appropriate management and follow-up. Staff members interviewed (12) and the three managers describe their responsibilities for ensuring the environment is safe at all times, consistent with the organisation’s documented systems. Feedback from residents and family/whanau through the annual satisfaction survey confirms that there is a high level of satisfaction with the environment (93%). Residents feel very safe and secure at Eileen Mary and compliment the maintenance staff member. ARC 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:** |
| The facility has been built in two stages and there are several types of rooms and one bedroom apartments. Individual rooms have either a hand basin, an ensuite toilet and hand basin, or an ensuite bathroom with wet area shower. Where there is not an ensuite bathroom, residents access shared shower rooms and toilets. In the higher acuity wing (Magnolia) there are 26 bedrooms; 22 of the 26 have ensuite toilets, one room has an ensuite bathroom, and remaining three have hand basins. In this wing there are three shared shower rooms, all of which are accessible to people who require mobility equipment, including hoists, for transfer. In the lower acuity wing (Range view) there are two, toilet/shower rooms for three bedrooms. In addition to these three bedrooms are the 19 residential care suites for people who require rest home level care. All residential care suites are one-bedroom units with an ensuite bathroom. There are an additional three toilets throughout the facility for staff and visitors to use. These are identified appropriately for use by visitors to the facility. ARC 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:** |
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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 1.4.4: 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:** |
| All bedrooms are individual and there are no shared rooms. Each resident can bring personal items, some furniture if they choose, and bed coverings to personalise their room. Furniture provided is appropriate for use and rooms are spacious enough to accommodate personal items, decoration and visitors. People have their own belongings and each room reflects the taste and personality of the occupant. The 19 residential care suites are purchased under a License to Occupy. All residents who occupy these suites receive rest-home level care. They allow for more personalisation and decoration to suit each individual. Personal property of all residents is respected by staff and visitors to the facility. Residents interviewed during the audit state that they are satisfied with their rooms, and the general environment. ARC 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:** |
| Eileen Mary has two separate dining rooms, one adjacent to the large kitchen in the facility. On entry to the service, people decide which dining room they would like to use, and can change if they choose. There is an additional craft and activities room which accommodates an indoor bowls ‘lane’ which is raised to allow for easier use by residents. Throughout the facility there are easy chairs in sunny locations which are always occupied during the audit visit by people sitting, reading or chatting with friends throughout each day. There is a large television lounge which can accommodate a large group of residents at any one time, as well as a large foyer area at the entrance which is also used for activities and socialising when extra space is needed. All furnishings, furniture and decorations in these communal areas are both attractive and appropriate to the needs of residents. ARC 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:** |
| Stage one: There is a cleaning services policy which states that the facility will be a pleasing, clean environment at all times. Cleaning of specific areas: bathrooms, toilets, hand-basins, showers and vacated rooms, is detailed in the policy. Stage two: House-keeping staff interviewed during the audit (the cleaning team coordinator and one of the laundry team) confirm that they are provided with effective cleaning and laundry chemicals and products. The Superclean representative visits the facility each month and conducts monitoring of the effectiveness of the cleaning products and equipment. Records of the monthly monitoring are held by the OM. She ensures that any anomalies are addressed, and if appropriate, are reported through the AIM reporting process. There is a locked and secure cleaners’ cupboard off the laundry. This is accessed by cleaning team members only and is otherwise locked. The cleaners’ trollies (two) are stored here when not in use. Bulk supplies of cleaning and laundry products are kept in the locked, separate, shed building used by the maintenance person. All secure areas are observed to be locked during the onsite audit, when not in use. In the 2014 satisfaction survey laundry and cleaning services received 95% and 99% satisfaction ratings. ARC 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:** |
| Stage one: There is an emergency plan for Eileen Mary which provides guidance on preparation for the range of civil defence emergencies which might be expected in New Zealand. Stage two: The OM has attended a local city council meeting in January 2014, in which preparation for emergencies and the support required by aged care facilities was discussed. The GM has been advised by the MDHB that they will not be able to transfer residents from the facility to the DHB and must be able to manage independently, or with assistance from local resources. The current emergency response plan includes ‘Get ready. Get through’ reference material and contacts for local civil defence headquarters. There are supplies of food and water for an emergency on site sufficient for three days. Fire safety and evacuation procedures are included in the orientation / induction programme. This is completed for all staff and is confirmed through review of a sample of personnel files (see 1.2.7). Evidence of 6 monthly fire evacuation practices is seen and confirms that these are current. Staff meeting minutes also confirm feedback on trial evacuations is discussed, when relevant. There is a call bell system in the facility which is activated by call bells in each bedroom and in all bathrooms (both ensuites and shared facilities). During the onsite audit call bell activations are observed to be responded to promptly. The facility external doors are locked at sunset and in the mornings from approximately 8am. During the onsite audit these doors were locked overnight as per these instructions. ARC 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 1.4.7.6 (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 building is constructed so that there is a large central courtyard and bedrooms, and the apartments, all have large windows which look out onto the courtyard or out onto views of the country-side. All bedrooms and communal rooms have external views and large windows. Bedroom windows can be opened safely for ventilation. The facility is heated with gas central heating and during the days of the audit was a comfortable, even temperature. ARC 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:** |
| Stage one: The Restraint minimisation and safe practice policy has an emphasis on restraints being the least restrictive option available. There is clear definition of restraints and enablers and that enablers are voluntary. The policy includes a description of roles for the medical staff, Eileen Mary restraint coordinator (who is the FM), RNs, the EN and health care assistants and caregivers. Restraint is used when safety is an issue and a resident is at risk of harm / falling / slipping. There are approved restraints of bed rails, tray tables, lapbelts, fall out chairs and lazy boy chairs. Use of any restraint follows an assessment by the restraint coordinator or an RN, involvement of the resident’s medical practitioner and after all other approaches have been tried and a resident’s safety is at risk. Restraints may be used without prior approval in an emergency, but if needed, verbal consent is to be obtained from a family/whanau member and must be fully documented in the resident’s file. A formal assessment and consent process should follow as soon as possible or within three working days. All restraints are to be discontinued as soon as there is no longer any justification for its use. Enablers which may be used at Eileen Mary are tray tables, bed rails and seat belt or lap belts. Enablers are only used when the individual is able to give consent and / or requests the use of the equipment (ie, an approved enabler). Stage two: Four files were reviewed in relation to this standard. One of these four is for a resident who uses an enabler (bed sides). The resident has clearly articulated their request to use bed rails so they feel safe when in bed. They have signed their consent form and were involved in the assessment conducted prior to the use of the enabler. The consent is current. ARC 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.)* |

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

Consumers receive services in a safe manner.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The FM is the restraint coordinator for Eileen Mary. She reviews the approved restraints used at the facility each year. The policy and procedure is current. The restraint register is also current and demonstrates that all restraints in use are approved restraints (bed sides, lap belts and tray tables). The restraint coordinator delivered annual restraint training in February 2014. Personnel files reviewed demonstrate that staff who are required to, have attended this training. Review of four residents’ files (one who uses an enabler and three who use restraints) demonstrates that the approval process has been followed and that only approved restraints are in use. ARC contract requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Assessment for the use of restraints follows a defined process and is implemented on all files reviewed for this standard. When enablers are used the same assessment process is employed to ensure that the process is transparent. The four files reviewed (three of restraint and one of enabler use) all have current assessments using the organisation’s procedures. Requirements of this standard are met in the assessment processes at Eileen Mary. The restraint coordinator at interview demonstrates that she understands the requirements of the standard for an effective assessment. There is a restraint register which records when restraints are first approved, that evaluations are current for each person who has an approved restraint. ARC contract requirements are met. |

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

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

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

Services use restraint safely

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Several residents are observed during the onsite with restraints in use. One person has a tray table to prevent him from falling when walking or changing location without assistance. He is observed over a period of time being monitored regularly by staff members and taken for hourly walks around the facility for up to 10 minutes at a time. Restraint specific documentation, and additional file documents, describe the need for restraint, alternatives and monitoring to occur for each person when the approved restraint(s) is in use. Documents reviewed demonstrate that family/whanau are involved in the decision to utilise restraint and when reviewing the ongoing need for a particular restraint. ARC contract requirements are met. |

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Stage one: Evaluation of restraint use is reviewed three months after their implementation and then at six monthly intervals or earlier if clinically indicated. Stage two: The four files reviewed all have a current evaluation, and records demonstrate evaluations have occurred regular as required over the past year (or more depending on the individuals need for restraint). Evaluation includes consideration of whether alternatives to restraint might be appropriate as well as the ongoing need for the restraint. ARC contract requirements are met.  |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The FM is the restraint coordinator and she undertakes quality review of restraint use every six months. The minimal restraints approved for use in the facility are consistent with the organisation’s stated intent of using restraint for safety and wellbeing of residents. At interview with the FM she demonstrates an understanding of intent of the standards and of the organisation’s restraint minimisation policy and procedures. She ensures that the use of restraint and enablers is reviewed regularly and that there is an emphasis on safety when in use and minimisation whenever appropriate. ARC contract requirements are met. |

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

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

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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:** |
| Eileen Mary has a clearly documented infection control programme (Last reviewed 30 January 2014) that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. The environment and practices sighted are consistent with documented policies and procedures. It is the responsibility of the facility manager to ensure appropriate resources are available (sighted) for the effective delivery of the infection control programme and it is her responsibility to implement the programme.The infection control practices are guided by the infection control manual and assistance from the MidCentral DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Reporting lines are clearly defined. The Facility Manager who is the infection control nurse records monthly infection rate data and presents a monthly report and graph at staff meetings. The Facility Manager reports to the organisation’s General Manager any serious infection related issues.. |

##### **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 Facility Manager (FM) is responsible for infection control at Eileen Mary. A position description is included in the Infection Control (IC) programme and in the FM’s job description.The infection control nurse/FM verifies there are enough human, physical and information resources to implement the infection control programme. Infection control training of the infection control nurse occurs via training through the MidCentral DHB and a private external IC consultant. The infection control nurse has access to diagnostic records to ensure timely treatment and resolution of infections.The infection control nurse facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. Any IC concerns are reported at the General Manager. The IC nurse reports to the staff meetings any IC issues on monthly basis. IC data is collected monthly and statistics and data is calculated and analysed.  |

##### **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:** |
| Eileen Mary has an infection control (IC) programme includes policies and procedures that cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the facility manager as current. Staff interviewed (12 of 12) are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry, nursing and kitchen staff are observed to be compliant with generalised infection control practices. A new staff member in the process of orientation, verified training in infection control during orientation. |

##### **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:** |
| Staff receives orientation and ongoing education, relevant to their practice as verified by nine of nine staff training records and 12 of 12 staff interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained.Resident education occurs in a manner that recognises and meets the residents and the family/whanau’s communication style, as verified by interview with eight of eight rest home residents, three of three hospital residents, one of one rest home resident family/whanau and three of three hospital resident family/whanau.There has been no evidence of Norovirus at Eileen Mary since 2011.  |

##### **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:** |
|  In line with Eileen Mary’s IC policy and procedures, monthly surveillance is occurring, as verified by documentation and 12 of 12 staff interviews. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. These are collated each month and analysed to identify any significant trends or possible causative factors. There is a staff meeting every month where the incidents of infection and analysis of data is presented. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. The data is made available on the staff notice board for staff to see. A yearly comparison based on previous incidents are used as a comparison if required. Findings are presented to the General Manager, with any necessary requirements discussed and actioned. |

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

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

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

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

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

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