Fairview Care Limited

Current Status: 2 July 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

Fairview Care is owned and operated by Premier Lifestyle Village. It is a privately owned company which operates two retirement villages and one aged care facility.

All services for Fairview Care are overseen by the general manager who has been in the role for six years. The general manager is assisted by the clinical manager who is an experienced registered nurse and has been in the role for six weeks.

Currently Fairview Care offers rest home and hospital level care to 47 residents. On the day of audit there are 44 residents, five rest home and 39 hospital residents. The facility has a village on site which operates as a separate company.

There are no areas identified for improvement in this audit.

The requirements of the provider's agreement with the district health boards are met.

Audit Summary as at 2 July 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

Indicator	Description	Definition
	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 2 July 2014

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

Organisational Management as at 2 July 2014

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

Continuum of Service Delivery as at 2 July 2014

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

Safe and Appropriate Environment as at 2 July 2014

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

Restraint Minimisation and Safe Practice as at 2 July 2014

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

Infection Prevention and Control as at 2 July 2014

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

Audit Results as at 2 July 2014

Consumer Rights

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

Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service. The advocacy service visits every six months for staff education and attendance at residents' meetings. Residents have access to visitors of their choice and are supported to access community services.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard.

Evidence is seen of informed consent and open disclosure in residents' files reviewed.

Residents and family/whanau understand and are happy to use the complaints process. Complaints management includes the use of information to improve services as appropriate. There have been two complaints to the Health and Disability Commission which are both closed. All required actions have been documented and completed by the service. At the time of audit there are no open complaints.

Organisational Management

The organisation's purpose, values, and mission statement are identified in the business plan. This document identifies how services are planned and coordinated to meet residents’ needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. Deficits to service delivery are managed through corrective action planning as appropriate.

Quality of service is reviewed and measured via the internal audit process, complaints management, resident and family/whanau satisfaction survey results, along with infection control and adverse event data collection and review. Quality and risk activities are reported on to the Board on a monthly basis and overseen by the GM. Identified deficits are used as opportunities to improve services as appropriate.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whanau interviews and in the 2014 satisfaction survey results.

The service implements safe staffing levels and skill mix. All shifts are covered by a registered nurse and all staff hold current first aid certificates. Human resources management processes implemented identify good practice and meet legislative requirements. Staff members’ knowledge and skills are maintained through on-going education which is appropriate to their role.

Residents' record information is stored in a safe and secure manner. Archived records are easily retrievable. Residents' file notes are current.

Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home and hospital level care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The clinical manager and registered nurses (RNs) oversee the care and management of all residents along with a team of health care assistants. All residents are assessed on admission and assessment details are retained in the individual resident`s records.

The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The resident and family are involved in the care planning and review. The general practitioner ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service.

The activities available are appropriate for residents requiring rest home and hospital level care. A full time activities coordinator oversees the activities programme and staff assist and undertake designated parts of the programme.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The clinical manager and RN are responsible for all areas of medication management and work alongside a contracted pharmacy.

Food service is contracted out but is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the clinical manager or RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

Safe and Appropriate Environment

There a comprehensive documented emergency response plan in place which is understood by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery.

The building has a current warrant of fitness and the service has an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit. Fire evacuations and emergency education is undertaken as part of orientation for new staff and regular ongoing education for all staff.

Furnishings and equipment are maintained to a high level to meet residents' needs. All bedrooms are single occupancy, with full ensuite facilities. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is appropriately heated and ventilated. The facility has level outdoor access which leads to appropriately shaded areas for resident use.

Restraint Minimisation and Safe Practice

Policy clearly describes that enablers are voluntary and the least restrictive option. The service has two enablers in use, both are bedside rails and there is documented consent for use by the residents. There are no restraints in use and the service actively works to ensure the environment remains restraint free.

Infection Prevention and Control

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

The clinical manager and infection prevention and control coordinator/RN participates in relevant ongoing infection prevention and control education. Relevant education is also provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, clinical manager and health care assistants in a timely manner. Overall infection rates and trends are discussed at the staff meetings (every second month).

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	Fairview Care Limited
Certificate name:	Fairview Care Limited

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit
Premises audited:	Fairview Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 2 July 2014 **End date:** 3 July 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	44

Audit Team

Lead Auditor	XXXXX	**Hours on site**	15	**Hours off site**	12

Other Auditors	XXXXX	**Total hours on site**	15	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	3

Sample Totals

Total audit hours on site	30	Total audit hours off site	23	Total audit hours	53

Number of residents interviewed	6	Number of staff interviewed	14	Number of managers interviewed	2
Number of residents' records reviewed	9	Number of staff records reviewed	7	Total number of managers (headcount)	2
Number of medication records reviewed	14	Total number of staff (headcount)	60	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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 Monday, 21 July 2014

Executive Summary of Audit

General Overview

Fairview Care is owned and operated by Premier Lifestyle Village. It is a privately owned company which operates two retirement villages and one aged care facility. There is a Board which consists of three people and a chief operating officer (CEO) elect.

All services for Fairview care are overseen by the general manager (GM) who has been in the role for six years. The GM is assisted by the clinical manager (CM) who is an experienced registered nurse and has been in the role for six weeks.

Currently it offers rest home and hospital level care to 47 residents. On the day of audit there are 44 residents, five rest home and 39 hospital. The facility has a village on site which operates as a separate company.

There are no areas identified for improvement in this audit.

The requirements of the provider's agreement with the district health boards are met.

Outcome 1.1: Consumer Rights

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

Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service. The advocacy service visits every six months for staff education and attendance at residents' meetings. Residents have access to visitors of their choice and are supported to access community services.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard.

Evidence is seen of informed consent and open disclosure in residents' files reviewed.

Residents and family/whanau understand and are happy to use the complaints process. Complaints management includes the use of information to improve services as appropriate. There have been two complaints to the Health and Disability Commission which are both closed. All required actions have been documented and completed by the service. At the time of audit there are no open complaints.

Outcome 1.2: Organisational Management

The organisation's purpose, values, and mission statement are identified in the business plan. This document identifies how services are planned and coordinated to meet residents' needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. Deficits to service delivery are managed through corrective action planning as appropriate.

Quality of service is reviewed and measured via the internal audit process, complaints management, resident and family/whanau satisfaction survey results, along with infection control and adverse event data collection and review. Quality and risk activities are reported on to the Board on a monthly basis and overseen by the GM. Identified deficits are used as opportunities to improve services as appropriate.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whanau interviews and in the 2014 satisfaction survey results.

The service implements safe staffing levels and skill mix. All shifts are covered by a registered nurse and all staff hold current first aid certificates. Human resources management processes implemented identify good practice and meet legislative requirements. Staff members' knowledge and skills are maintained through on-going education which is appropriate to their role.

Residents' record information is stored in a safe and secure manner. Archived records are easily retrievable. Residents' file notes are current.

Outcome 1.3: Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home and hospital level care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The clinical manager and registered nurses (RNs) oversee the care and management of all residents along with a team of health care assistants. All residents are assessed on admission and assessment details are retained in the individual resident`s records.

The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The resident and family are involved in the care planning and review. The general practitioner ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service.

The activities available are appropriate for residents requiring rest home and hospital level care. A full time activities coordinator oversees the activities programme and staff assist and undertake designated parts of the programme.

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Food service is contracted out but is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the clinical manager or RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

Outcome 1.4: Safe and Appropriate Environment

There a comprehensive documented emergency response plan in place which is understood by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery.

The building has a current warrant of fitness and the service has an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit. Fire evacuations and emergency education is undertaken as part of orientation for new staff and regular ongoing education for all staff.

Furnishings and equipment are maintained to a high level to meet residents' needs. All bedrooms are single occupancy, with full ensuite facilities. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is appropriately heated and ventilated. The facility has level outdoor access which leads to appropriately shaded areas for resident use.

Outcome 2: Restraint Minimisation and Safe Practice

Policy clearly describes that enablers are voluntary and the least restrictive option. The service has two enablers in use, both are bedside rails and there is documented consent for use by the residents. There are no restraints in use and the service actively works to ensure the environment remains restraint free.

Outcome 3: Infection Prevention and Control

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

The clinical manager and infection prevention and control coordinator/RN participates in relevant ongoing infection prevention and control education. Relevant education is also provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, clinical manager and health care assistants in a timely manner. Overall infection rates and trends are discussed at the staff meetings (every second month).

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	44	0	0	0	0	0
Criteria	0	89	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	6
Criteria	0	0	0	0	0	0	0	12

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Residents' rights at Fairview Care includes a Code of Consumers' Rights that replicates the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Staff receive education on the Code at orientation and at in-service training sessions (in-service education plan 2014 sighted). The service's compliance with the Code is monitored through resident and relative satisfaction surveys which confirm satisfaction. Three of three residents' family member and six of six residents interviewed confirm satisfaction with the service.

Interviews with the clinical manager, three RN's, four health care assistants and one chaplain confirm they have a good knowledge and understanding of residents' rights.

Observed during the provision of care were residents being given choices, residents' decisions being respected, residents being treated with respect, residents' privacy being protected, and residents being addressed by a preferred name. Clinical staff are observed to explain procedures being undertaken and seek verbal acknowledgement for the procedure to proceed prior to it being commenced.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

Stage one: Resident rights during service delivery are clearly described in policy.

Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) in the admission pack. Brochures and posters are on display and are accessible to all personnel entering Fairview Care. This information is also included in the resident's information booklet, as is a copy of the complaints procedure, that is handed out to all admitted and prospective residents, prior to admission. A list of interpreters is available through the Waitemata District Health Board (WDHB) should assistance be required to provide the information in a language and format that is suitable to the consumer.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The organisation has comprehensive policy which identifies no form of abuse or neglect will be tolerated. Reporting procedures shown in policy state that if the allegation or suspicion of abuse is discovered by a staff member then they should inform the manager or senior staff member as soon as possible.

Resident rights are clearly identified in policy. Policy also states that issues around intimacy and sexuality are appropriately managed ensuring residents' rights are protected but the rights of other residents and staff are not compromised.

Interviews with three of three family/whanau members and six of six residents confirm they have no concerns related to abuse, neglect, discrimination, harassment or exploitation at Fairview Care.

All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. As observed, staff close doors when undertaking personal cares and discussions. All rooms have telephones provided with a DDI, enabling residents to have privacy when making phone calls. There are locks and signs on all toilet and bathroom doors and staff always knock on their door prior to entering.

There is a nurses' station in each wing with locked cupboards for residents' files. Interviews with four of four healthcare assistants, three of three RNs, six of six residents, one of one cleaner, one of one activities officer and three of three family/whanau members confirms privacy is maintained as appropriate.

Care planning interventions sighted in nine of nine residents' files (eight hospital, one rest home) reviewed and interviews with residents and staff, confirm time is allowed

within care provision to encourage residents to be as independent as possible, whilst ensuring their safety. Six of six residents interviewed describe being given choices over many aspects of their daily living, being able to choose what they wear and when they do things.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The Maori Health policy for Fairview Care states the service shall:

- Recognise and respect the principles of the Treaty of Waitangi
- Provide culturally and clinically effective services to Maori residents.

The action taken to meet the above statement is clearly shown. This includes Maori participation in health planning and participation, to work in partnership and / or in consultation / liaison with local iwi / hapu / whanau and to consider new and innovative policy and practise built upon existing Maori health strategies. The service maintains links with the Waitemata DHB Maori Health Services for advice as required.

There is one Maori resident at Fairview Care who advised they do not identify with the Maori culture. They report that they are given the opportunity and are extremely happy with the care given to them.

Staff receive annual education in relation to cultural safety and The Treaty of Waitangi (sighted).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)
The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)
Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

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

Attainment and Risk: FA

Evidence:

Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided (confirmed in interviews with six of six residents and three of three relatives interviewed) and review of satisfaction survey.

Evidence is seen of the initial assessment plan the opportunity for residents to express their individual cultural needs and how these can be recognised.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Orientation/induction processes at Fairview Care include informing staff on the house rules and code of conduct. The staff job descriptions, employment agreement and house rules provide clear guidelines on professional boundaries and conduct. Thirteen of thirteen staff interviewed are aware of Fairview Cares expectations on behaviour and conduct.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Policy related to good employment practices are in place. Policy states that it is important that staff employed are aware of their rights as well as their responsibilities. The rights of the employees are as follows:

- To work in a safe working environment in which staffing levels are consistent with current legislation and reflecting the needs of our residents.
- To work with staff that are appropriately qualified.
- Recruitment procedures will be designed to ensure competent staff is employed.
- The staff is responsible to work within their scope of practice
- To be appropriately supervised
- To receive ongoing training

Policies and procedures are evidenced based and reflect current good practice.

Evidence is seen of care staff undertaking or having completed the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificates (sighted) and all staff who administer medication have yearly assessments to determine competency.

Registered nurse education is supported by WDHB and all are part of the professional development and recognition programme (PDRP) and have an up to date CV. The planned yearly education programme (operating and sighted), includes sessions that ensures an environment of good practice. The food service is contracted out and all cooks have fulfilled the requirements of safe food handling.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy related to communication identifies the meetings, notice boards, newsletter, posters, and in-house education procedure, guest speakers, induction programme, signage and the communication book are used to ensure consumers have full and frank information passed on. Policy is reflective of open disclosure measures.

Interpreter services are available as required. Nine of nine files (eight hospital, one rest home) files reviewed provide evidence of resident family/whanau input in assessment and care planning process, progress notes and communication records of family contact via phone. Evidence is seen of completed incident reports and family being informed of the incidents.

Interviews with three of three family members and six of six residents confirm they are happy with the information and involvement they receive from Fairview Care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy sighted meets legislative requirements related to advanced directives related to resuscitation. Information is clearly written in a language that is easy to understand for residents, relatives and staff. There are comprehensive informed consent policies that identify family/whanau involvement as appropriate.

Informed consent is evident in observation of day to day activities on the two days of audit, with residents being actively involved in the decision making process. Nine of nine files reviewed contain evidence of informed consent forms signed on admission. All medicine charts have residents' photographs for identification.

An advance directive enables a resident to choose if they would like: antibiotics for a chest infection; resuscitation in the event of cardiac, respiratory or cerebral collapse; active medical treatment to prolong life; transfer to base hospital for on-going treatment. The advance directive is filled out in consultation with the resident's doctor, with consent or non-consent to be revoked at any time. Nine of nine files have signed advance directive forms. Staff receive education on informed consent and the HDC Code of Rights. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services Fairview care.

Family members and residents are actively involved and included in care, food, fluids, activity, outings, requests for doctors, treatments, interventions and specialist treatments as evidenced in nine of nine residents' files, three of three family and six of six resident interviews.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy identifies that the service respects the resident's choice to advocacy and support.

Six of six residents, three of three family members and ten of ten staff interviewed confirm they are aware of the advocacy service. The chaplain was interviewed and had no concerns with the care facility during her weekly visits.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents are encouraged to maintain links with their family/whānau and the community. The facility has requested visiting hours from 1pm – 8pm. The general manager (GM) and the clinical manager (CM) report on interview that the families and residents are aware of the reason for the hours, which is to give the care staff time to undertake cares. If family can only visit out of these hours each case is considered and usually approved to visit earlier. Residents and families report on interview that they are aware of the visiting hours and are satisfied. Residents are free to access community services of their choice and the service utilises appropriate community resources.

Residents interviewed confirm their ability to have access to visitors and community services. Individuals are encouraged to maximise their potential for self-help and involvement in the wider community by accessing public libraries and shops in the area. The activities programme also supports bringing the community resources into Fairview care for those who may not wish to go out into the community.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy identifies that the service has an easily accessed, responsive and fair complaints process in place to comply with Right 10 of the Code. There is a complaints register in place and a specific form for complaints follow up. The register identifies the complaint made, date, actions taken, advocacy process commenced and the outcome. A complaints flow chart makes all steps quickly and easily identifiable for staff to follow. Policy states that all complaints will be documented, followed up and trends analysed in order for corrective action to be taken if appropriate. Everybody has the right to complain, which can be in writing or verbally.

Stage two: The GM and CM confirm that upon entry to the service complaints management is part of the information that is discussed with the resident and family/whanau. This is confirmed during three of three family/whanau and six of six resident interviews (five hospital and one rest home level). Complaint forms are available from the reception area.

Interviews with 14 of 14 staff from across various service (one cook, the activities coordinator, one enrolled nurse (EN), one household supervisor, one cleaner, three registered nurses (RNs), one gardener, four healthcare assistants and one chaplain) plus the GM and CM, confirm their understanding and implementation of complaints management to meet policy requirements. All complaints are documented in a complaints register and signed off by the GM when a response is satisfactory to the complainant and all corrective actions have been set in place as appropriate.

There is an up to date complaints register which identifies the complaints received have been responded to in writing. All actions taken to address the complaints are clearly documented and signed off when the issue has been dealt with to the satisfaction of the complainant. There are no outstanding complaints at the time of audit. The service has had two complaints registered with the Health and Disability Commissioner. One which began in 2011 and was closed in 2014 following a full investigation and another which was made in July 2013, no follow up actions were required and it as closed in January 2014. ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Fairview Care have a business plan which drives the business and steers all decisions made in policy making and budgeting. It identifies the direction of the business and all staff have access to the plan. The Business Plan is reviewed annually to identify reached goals. The quality statement in policy identifies that the organisation shall continuously strive to improve care, people and processes, and relationships with customers and suppliers whilst achieving growth.

The company's management team is committed to achieve a working environment based on trust, respect, co-operation and teamwork to encourage innovation, efficiency

and productivity to create a safe, satisfying and rewarding environment for employees. Job descriptions sighted identify that the person/s heading the organisation are suitably qualified and experienced for the role they undertake.

Stage two: The organisation's philosophy, mission statement, and vision have a focus on quality strategies and identify that services are planned using a host of resources covering all aspects of service delivery as described in the current business plan which was reviewed in June 2014.

The business and quality plan has easy to measure goals which cover all aspects of service delivery both clinical and non-clinical.

The organisation's management structure shows that all care services are overseen by the GM who has been in the role since 2008. She is supported by the CM who is a registered nurse and manages all clinical areas. The CM has only been in the role for six weeks but is an experienced RN who has a past history in management and education. Both staff members undertake appropriate ongoing education with the CM being registered with Waitemata District Health Boards Professional Development and Recognition Programme (PDRP).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy states that in the case of the manager's absence, timely arrangements are made to relocate the absentee's duties to a suitable person or to a management member of the staff. The '2IC' has been charged with these duties.

Stage two: During a temporary absence of the CM a senior RN undertakes the role. If the GM is on leave the administrator, the CM and the CEO undertake associated duties.

This is undertaken as part of orientation and ongoing succession planning.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The organisation's quality and risk plan details the risks, current controls and ongoing actions taken to limit exposure. It identifies the organisation's commitment to compliance with contractual requirements by the implementation of documented quality management systems. Policies and procedures fulfil the domains of quality to reflect:

- Efficiency
- Effectiveness
- Safety
- Responsiveness
- Accessibility.

The quality goals and objectives shown are consumer focused, identify risk management processes and provision of effective programmes, show how contractual requirements are met, and describes the continuous improvement processes including corrective action planning process which provide opportunities for improvement.

The organisation has a documented system in place to ensure any amendment, additions or updates to policy are shown. Policies and procedures are updated at least two yearly or as required to meet legislative and good practice requirements.

Health and safety policies and procedures identify actual and potential risk and how they are managed. The hazard policy ensures all existing and potential hazards are identified, acted upon and the risk of repetition is minimised. The process shown identifies that staff, visitors and residents are informed of hazards as appropriate. The hazard register sighted identifies that risks are prioritised, the action that is taken to eliminate, isolate or minimise the hazard and the frequency of review.

Monthly data information is discussed at staff and management level. Monthly analysis forms sighted for incidents and accidents, infection control data, falls. Monitoring, assessment, evaluation and feedback process identify how key components of service delivery are linked to quality management systems.

Stage two: All policies and procedures are up to date and personalised to the facility. The organisation ensures compliance of the quality and risk management processes. Regular audits are undertaken and corrective action planning is clearly documented for any deficits found. Data is collected, trended, evaluated for all key components of service (complaints, incidents and accidents, hazards, health and safety, restraint, and infection control). This information is shared with staff, management and the Board as confirmed in meeting minutes sighted. Staff report they understand and are kept well informed of all quality measures and corrective actions. A full annual review and report is collated using all relevant data and the effectiveness of corrective actions is shown and discussed. This information helps inform the business and quality plans.

Quality improvements show the issue found and the corrective action taken to address the issue. All processes are clearly documented and staff, residents and family/whanau interviews confirm any concerns they have are addressed by management.

Six monthly multidisciplinary meetings which family/whanau are invited to attend are used to share information. The results of the annual resident satisfaction survey for 2014 show that all concerns have been addressed. (The majority of comments relate to food portion sizes and these have been addressed by the food service manager).

Actual and potential risks are identified and documented in the hazard register. The service has a health and safety officer who leads the monthly process of ensuring all identified hazards are safely managed. Newly found hazards are communicated to staff and residents as appropriate. Any new hazards that cannot be eliminated and that

effect resident areas are published in the monthly newsletter which is given to every resident and available to family/whanau members. Staff confirm during interview that they understand and implement documented hazard identification processes.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the

status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The provider understands their statutory and regulatory obligations in relation to essential notification such as infectious diseases being notifiable to a Medical Officer of Health and Local Authority, serious harm notification and reportable events to the Ministry of Health as stated in policy.

Policy related to incident and accidents states all adverse, unplanned or untoward events are systematically recorded, investigated and analysed and appropriately statutory agencies are notified of essential information by manager. The incident and accident form identifies if family/whanau are informed. At the end of each month the data collated related to incidents and accidents is analysed ensuring a trend is identified at the earliest opportunity and appropriate corrective action instigated to prevent deficits happening again. Original form is placed in the resident's file after analysis. Falls management is well documented.

Stage two: During interview the GM and CM report their understanding of what adverse events require reporting and the regulatory obligations related to this.

All incidents and accidents are recorded on a specific form. Adverse event data is collated and trended against previously collected data. Incident and accident information is used to identify areas of improvement as appropriate. One example relates to skin tears and a special staff meeting was held to 'brain storm' and present additional education, such as the showing of the Ministry of Health video related to 'compassion' to make staff more aware of the need to ensure equipment is used safely and that resident cares are not hurried. Incident and accident information is shared at staff meetings as shown in minutes sighted and confirmed during 14 of 14 staff interviews.

The Board report also identifies the number and type of incidents and accidents and shows the actions taken to prevent or lessen other like type events.

Family/whanau are kept informed of all incidents, accidents, adverse events or concerns as confirmed in nine of nine residents' files and during three of three family/whānau interviews.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Staff qualifications are validated upon employment and annually thereafter as appropriate. All staff education is documented. Annual staff appraisals are undertaken and used to identify any areas of special interest to staff so further education can be put in place or areas of the employees work requirements that need additional mentoring.

Stage two: Professional qualifications are validated as part of the employment process and ongoing annually. Annual practising certificates are sighted for eight RNs, one EN, the dietitian, podiatrist, physiotherapist, three GPs and six pharmacists. Healthcare assistance are supported and encouraged to complete recognised aged care qualifications.

Policies and procedures implemented identify that good employment practice and legislative requirements are met. This is confirmed in a review of seven of seven staff files (one EN, two RNs including the CMs, the activities coordinator, two HCAs and the housekeeping supervisor). Signed job descriptions and employment contacts are sighted in all files.

There is a comprehensive orientation programme in place with specific competencies for related roles as sighted in file reviews. Staff ongoing education covers all areas of service provision and is clearly documented under each staff member's name. There is an annual in-service education calendar in place and the CM actively works to offer staff off-site education related to the role they undertake. Education includes food safety, safe chemical handling, emergency education, infection control, restraint management, safe medicine management and palliative care. This is confirmed during 14 of 14 staff interviews.

The RNs and the EN are all registered with WDHB and undertake specific education to ensure they meet all Nursing Council of NZ requirements via the PDRP. Portfolios are kept up to date as sighted in two RN and one EN file review.

Staff appraisals are up to date, including a three month review for a newly appointed HCA. All staff are required to hold current first aid certificates and this is monitored by the CM.

Interviews with residents and family/whanau and the satisfaction survey results identify residents' needs are met by the services delivered. No negative comments were voiced on the days of audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The organisation has a staffing levels and skill mix policy which states the managers, or delegated person, have discretion to extend hours and staff numbers to respond in certain situations (ie, special events, emergencies, resident acuity issues, outbreaks). The staffing level as identified on the roster reflects the number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience.

The clinical manager is responsible to ensure that each shift is filled by a staff member with the appropriate experience and skills. New staff members will always be supervised by a senior staff member and not work by themselves until deemed competent. Staff working in senior positions have the necessary qualifications and competence to do so. Staff levels reflect resident's assessed needs.

Stage two: The service operates a six week roster. This identifies that staff are replaced for sick leave and annual leave as appropriate. When the number of residents decreases the GM stated that they may work with one less HCA on morning or afternoons as long as this is deemed safe practice by the CM. Rosters identify that all shifts are covered by at least one RN

- Morning shift has two RNs or one RN and one EN and nine HCAs. Monday, Wednesday and Thursday there is an additional four hour shift to assist with showing.
- Afternoon shift there are two RNs and six HCAs (two finish at 2100 hours).
- Night shift has one RN and two HCAs.

The CM stated that she has authority to increase staffing hours to meet acuity levels if required.

There are dedicated laundry hours (55 hours per week), kitchen assistants for the care facility kitchen (87.5 hours per week) and cleaning staff (82 hours per week).

The activities coordinator works Monday to Friday.

Monday to Friday the GM and CM work eight hours per day.

Maintenance staff who are employed by the village are available on call and dedicate eight hours per week for the care facility.

There is a GP on call until 8pm and then emergency services are used as required. The service has put processes in place to ensure GPs have time to see all residents that require review. This is an improvement made in response to Health and Disability Commissioner requirements.

The GPs and the service are currently working on a specific resident/GP allocation to provide more personalised service to residents. The GP interviewed stated this process is well into the end stages of development. This quality improvement has occurred in response to the 2014 resident satisfaction survey result responses.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Prior to entry, the resident must be assessed by the Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure they require rest home or hospital level care. Access and entry criteria are documented and communicated to residents and their family/whanau by local doctors, referral agencies, the DHB hospital and local

community groups. An information pack about Fairview Care services is available and outlines details of the service.

If a telephone enquiry is received from someone who has not been assessed, they are advised to contact their GP or the local NASC agency. All enquiries are documented on a facility enquiry form. Entry criteria is verbally explained to anyone making an enquiry and information packs are sent out or given to prospective residents when they call in. Prospective residents/family/whanau are encouraged to tour the facility with the admission coordinator and make time for discussion with the clinical manager as required.

The service has a good working relationship with the local NASC agency, doctors and community agencies who are aware of the level of care offered by Fairview Care and the process required to access that care.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

All enquiries are documented on a facility enquiry form and these are kept in an enquiry folder. Prospective residents are declined entry if a bed is not available or a resident was deemed unsuitable. The service has a close relationship with the local NASC agency, and referring agencies. If a resident was deemed unsuitable this would be done in consultation with the NASC agency. These agencies are informed by Fairview Care of their bed status as vacancies become available.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy identifies all assessment needs of residents are undertaken by competent and appropriate registered staff.

Service delivery documentation is overseen by the CM. Documentation is part of the audit process and reviewed at regular intervals to ensure it is completed within required timeframes. In the nine files reviewed there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed in the required timeframes. Fairview Care uses the interRAI computer programme for assessments and care plan evaluations. The CM and RN's have completed the interRAI training. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed.

The CM reports there is a process for annual multidisciplinary resident review. There is evidence in the nine files reviewed that the family/whanau are involved in all care changes and reviews. Handover at the beginning of each shift is undertaken in each wing of the facility. Fairview Care have the services of two contracted GP's who visit twice weekly or at other times if required. There is a GP on call 24 hours a day and seven days a week (24/7) to cover for all residents.

The four health care assistants and three RN's interviewed report that the Gerontology Nurse Specialist for the Older Persons Health from the WDHB visit as required and a referral is made to a dietitian for any unexplained weight loss.

The three relatives interviewed are very positive about the staff, GP and all aspects of care. The nine clinical staff interviewed report that they are kept up to date with all clinical changes.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage One: All wounds are notified to the RN who is required to undertake a wound care assessment. A comprehensive form is sighted. The Abbey pain scale is used to determine medication management. Incontinence management and assessment forms are sighted covering bowel, bladder and specialised stoma cares. Coombes assessment processes are used as part of the falls management programme. Challenging behaviour assessment and monitoring forms are in place with relevant procedures to guide staff actions. Restraint assessments and monitoring forms inform the restraint care plan.

A full nutritional assessment is carried out including documenting special dietary requirements, likes, dislikes, allergies and preferred meal times. This information is passed on to the cook. A record of the resident's weight is taken and reviewed monthly. Nine of nine files reviewed note residents' weights as stable. Six of six residents described satisfaction with meals.

The CM has recently implemented the 'Top To Toe Assessment ' initiative. This involves a resident of the day is identified the plan of the programme is to be a preventative programme to reduce any short complications. This includes health care assistants completing personal cares and checking clothes, rooms, dentures and glasses. The RN will check observations and care plans. This is a trial and every resident will be assessed and the trial will be evaluated at the end of this time.

A falls assessment is performed to identify a resident's level of risk for falling and this is reviewed as residents' needs change, or six monthly. Residents identified as a falls risk have interventions documented in the care plan that are implemented to minimise the risk.

A medical assessment is undertaken within a day of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. Sighted in nine of nine residents' files, comprehensive assessments completed on admission and reviewed six monthly or as needs change. A behaviour chart in one file covers areas of challenging behaviour, contributing factors, triggers, management strategies and medication. Pain assessment and management is sighted in a file of a resident requiring pain management. Skin tear management is sighted in a file of a resident with a skin tear. Causative factors identified in relation to the skin care have been

identified. A recently admitted resident has all required assessments and documentation completed.

Nine of nine files, three of three family and six of six resident interviews, verify residents and family are included and informed of all assessment updates and changes in residents' needs.

All clinical staff interviewed, confirm they use 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The planning of care is discussed with the family. In all nine files reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk and pressure area risk. All health professionals document in the resident's individual clinical file. Documentation in all nine files reviewed include nursing notes, medical reviews and hospital correspondence. In all nine residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. The five families interviewed report they are totally consulted in all aspects of their care. The clinical staff report on interview they are updated at handover, or earlier, of any care changes.

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

In the nine files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents' desired outcomes are being met. A specific example is a resident whose family reported on admission that he did not like to eat with other residents. There is evidence the clinical staff have implemented a plan to ensure that, if he chooses, he is able to eat in his room or a quiet area of the dining room.

The clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is one activities coordinator who works a total of 30 hours each a week employed at Fairview Care. Activities are available for all residents over seven days as the caregivers undertake activities during the hours when the activity coordinator is not on site.

The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. The activities coordinator has attended a three day Spark of Life course. Since completing the course she has completed in-service education sessions with the staff on this philosophy and is undertaking to enrol volunteers to complete the ten week course. She attends two monthly diversional therapy meetings with activities staff from other local facilities.

External visits for the residents include drives to local areas and coffee groups and ‘beer club’ have been commenced. The six relatives report on interview the activities are positive and the residents enjoy the programme.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In the nine files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service.

Individual short term care plans are seen for wound care, infections and challenging behaviours. These are kept in the resident's file and daily documentation is made in the progress notes. These are transferred to progress notes when completed or transferred to the long term care plan.

The progress notes are signed each duty by the RN. Evidence is seen of the family/whanau involvement in the care reviews. The three relatives report that they are given the opportunity to be involved in all aspects of care and reviews.

The nine clinical staff interviewed have knowledge of the care plan documentation requirements.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes in the diary. The family will be notified of the upcoming appointment and will be invited to attend and assist. The facility aims: to ensure that we facilitate a planned transition, exit, discharge or transfer in collaboration with the resident; to ensure that we identify, document and minimise risks associated with each transition, exit, discharge or transfer, including expressed concerns of the resident or their representative; to ensure that every effort is made to make the process as non-disturbing as possible and undertaken with clarity, compassion and respect. Exit forms identify all known risks or areas of concern. Policy identifies that referrals to other agencies are sent as required. This includes NASC, podiatrist, physiotherapist, spiritual advisors, medical specialists, interpreter services, dentist, audiologist, solicitor, accountant and other.

Nine of nine residents' files reviewed required referrals to other health services. Sighted in residents' files is information relating to the referral process. Residents are given a choice of GP when they are admitted. Most residents use the GP contracted to Fairview Care. If the need for other services are indicated or requested, the GP or CM sends a referral to seek specialist service provider assistance from the WDHB. The resident and the family are kept informed of the referral process.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

There is a specific transfer form to document information involving the resident to the WDHB or other facility. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate. When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and observations. A verbal handover is given by the CM. Communication is maintained with the family at all times, as confirmed during interview of three of three family members and six of six residents. There is open communication between the service and family/whanau in relation to all aspects of care, including exit, discharge or transfer.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: There are clearly documented medicine management policies and procedures which cover all aspects of legislation requirements. Policy describes the medication blister pack and safe delivery procedures. The Abbey pain scale is used as part of medicine management procedures.

Fairview Care use the blister pack medicine system whereby medicines are delivered monthly, except for as required (PRN) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the CM or RN and evidence is seen of the signing sheet. There are controlled drugs on site and all processes comply with the legislative requirements.

There is evidence in all fourteen medication charts reviewed that they are reviewed three monthly by the GP.

There are standing orders used at this facility and they comply with guidelines for aged care .

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The CM reported that the GP works with the pharmacy but he/she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he/she charts on the medication sheet.

The RNs are responsible for medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines.

There is no self-administration of medicines at Fairview Care

Medicine sheets are signed in ink as required following administration.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policy states that the contracted food service operator has comprehensive documented current policies and procedures which reflect contemporary professional knowledge and principles of nutritional care and food service management, and are consistent with service objectives, relevant regulations, and requirements of statutory authorities. The policies and procedures are designed to manage food safety. The programme looks at all the stages involved in producing food (from ingredient purchase through to final stage), identifying things with the potential to cause harm to the resident (the hazards), and implementing controls to eliminate or control such hazards. Residents are provided with a balanced varied diet, which provides for the individual's health status, personal likes and dislikes, religious or ethnic restrictions and medical modifications. The final menu is approved by a nutritional consultant.

Food services are contracted out to a company who operates a four weekly menu cycle approved by a dietitian (sighted). An individual dietary assessment is completed on admission which identifies individual needs and preferences. Likes and dislikes are identified as part of the admission assessments. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. There are two cooks who work over seven days. Both are to update with their food safety certificate. Evidence is seen of attendance at annual update on infection control and first aid. The cook reports on interview that she is supported by management on food supplies and understands the individual requirements of the residents.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)
Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)
Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)
All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: The organisation has clearly documented process for the safe and appropriate storage and disposal of waste and infectious or hazardous substances that complies with legislative requirements. This includes ensuring all chemicals are correctly labelled and the correct disposal of sharps. Procedures identify the correct use of personal protective clothing and equipment. Policy is in place to ensure that all rubbish and recycling fits within the parameters of the Auckland City Rubbish and Recycling Plan. Procedures describe the actions to be taken to meet all aspects of policy.

Part two: Chemicals are supplied by an approved supplier who ensures safety data sheets are kept up to date. Safe use of chemicals is included in the annual education calendar and was last presented in May 2014. All chemicals are securely stored.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons and goggles. Interviews with 14 of 14 staff confirm they can access PPE at any time. Staff are observed wearing disposal gloves and aprons as required.

Approved yellow sharp bins sighted are used for the safe disposal of sharps.

The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation. The service manages its own waste disposal and the documented process is followed to ensure safe disposal of all waste. All rubbish bins are emptied twice daily and then the bins are sanitised before being reused. Waste bins are colour coded to identify the waste they contain. There are no specific territorial authority requirements related to waste care management.

The service actively recycles as part of good practice for waste management.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 21 February 2015.

Maintenance is undertaken by both internal maintenance teams and external contractor as required. This is confirmed in the maintenance book sighted. Long and short term maintenance is documented and overseen by the operational maintenance manager. A member of the maintenance team is on call at all times.

Electrical safety testing occurred in April 2013 by an approved provider and all newly purchased equipment is approved before use. Clinical equipment such as oxygen concentrators, nebulisers and weigh scales are tested annually on a contractual basis. The electric beds were last serviced in October 2013 and this is also an annual contracted service. Laundry equipment is tested on a monthly basis.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. Regular environmental audits sighted identify that the service actively work to maintaining a safe environment for staff and residents. There is a 15 year maintenance plan in place which identifies all upcoming refurbishment and decorating.

Access to the building is via a lift from the car park. The building design ensures that there are same level external exits onto appropriately furnished outdoor areas for resident use.

Interviews with six of six residents and three of three family/whanau members confirm the environment is suitable to meet their needs.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All resident bedrooms have full ensuites.

Sanitising hand gel is available in all areas. Hot water temperatures are monitored and all resident rooms have tempering valves to regulate hot water. The service has a documented process for measuring hot water at the source of heating and then into the care complex. The service has commenced a recording process to ensure the point of delivery of the hot water remains below the required 45oC safe temperature.

There are separate staff and visitor toilets.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All bedrooms are single occupancy. They are personalised to meet residents' wants and needs and are large enough to allow residents with or without mobility aids to move around safety. Resident's personal belongings are stored in their bedrooms.

Interviews with residents and family/whanau confirm they are happy with their bedrooms.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are two lounge areas and the dining area is separate. Areas are furnished to a high standard. Activities are undertaken in the main lounge area.

Interviews with six of six residents and three of three family/whanau members confirm they feel all their internal environmental needs are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are procedures in place related to laundry and cleaning processes. The laundry is extremely well equipped and an approved provider maintains monthly monitoring for effective use of washing machines. Laundry and cleaning staff confirm they have adequate dedicated hours which allow them to complete all tasks. As observed PPE is readily available and used appropriately during cleaning processes. The laundry has a good clean/dirty flow.

Chemicals are appropriately labelled and securely stored. One bottle of 'urine off' was not correctly labelled and was removed on the day of audit. Labels are being sourced by the housekeeping supervisor. Up to date safety data sheets are available in all areas chemicals are kept.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has an emergency supplies which are checked regularly to ensure all equipment and supplies are within expiry dates. This includes food and water supplies.

There is a very comprehensive emergency plan which is used in staff education to ensure everyone is aware of actions to take if a disaster occurs. The organisation has an agreement with a local company for a large portable generator which allows uninterruptible power supplies to the facility so that communication and power is available for up to 12 hours. (This has been tested at the facility). The facility is on the Auckland City Council and Civil Defence alert list and alerts are sent via electronic media. All areas have a comprehensive emergency phone number list which is regularly updated to ensure all information is current.

There have been no changes to the facility foot print since the previous audit and the evacuation plan remains unchanged. Six monthly trial fire evacuations are conducted and times are monitored and report against to the Board. Fire equipment was checked by an approved provider in May 2014.

All staff are required to hold current first aid certificates. This process is monitored by the CM.

The entry to the grounds of the facility is gated. The gate closes at night and opens at 6am. When the gates are locked there is a bell for visitors to ring. Request for entry is responded to by staff at reception who can see the visitor via a monitored screen. There are CCTV cameras at the entrances to the building, at the front gate, at lift entrances, in the underground garage and on the main driveways. This allows staff to monitor the activities within the complex. Afternoon staff in the care centre are required to ensure doors and windows are securely closed at night. This is confirmed during staff interviews.

Call bells are sighted in all residents' bedrooms. When the bell is activated an audible ring occurs and ceiling mounted information identifies which area it is. If the bell is not answered within three minutes the call alert changes colour to indicate this. This occurs every three minutes and is monitored via computer.

Resident interviews confirm call bells are answered in an acceptable timeframe.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All resident areas have at least one opening window and/or door which provides natural light and ventilation. The facility is heated by under floor heating and is fully air conditioned. Every resident bedroom has a thermostat which allows individual heat control to suit each resident's heating requirements. The facility was warm and well aired on the days of audit. Residents and family/whanau state that the facility is kept at a suitable temperature throughout the year.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Stage one: Restraint approval and processes are clearly documented. Policy identifies the organisation actively works at ensuring the use of restraint is actively minimised. Policy states the use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident's independence and safety.

Stage two: The restraint policy in place reflects safe and appropriate use of restraint. Interviews with nine of nine clinical staff identifies their knowledge and understanding of correct restraint processes. Currently the CM is in the process of personalising the restraint policies and procedures to better reflect the no use of restraint, other than enablers. Documentation includes a pre-assessment to identify the use of enablers and the expected outcome is to promote resident independence whilst remaining safe. The enablers are shown in the restraint register and reviewed at least six monthly.

Fairview Care has two enablers in use which are both bedside rails. No other restraint is currently in use. Both residents who are using enables file reviews indicate that the resident has signed consent for enabler use. One pre-assessment form could not be located in the resident's file but was completed on the day of audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Stage one: Documentation identifies that the infection control programme is developed in consultation with relevant key stakeholders, (microbiologist, registered nurses and other health professionals). Management, including the infection control coordinator, approve the programme. The programme is reviewed at least annually. The designated persons (all health care assistants) shall implement standard precautions into their residents' care practice. They will attend regular in-service education and this policy will be reviewed yearly through an audit.

There is a clearly documented infection control programme that aims at establishing, maintaining and monitoring procedures covering infection control practices, monitoring, reporting and analysing data, education and training, cleaning and documentation, housekeeping, waste disposal and laundry operations.

Reporting lines are clearly defined, with the infection control coordinator role being undertaken by the RN in each wing. The Infection control coordinators record monthly infection rate data and present at monthly staff meetings. They notify the WDHB of any serious infection related issues.

There is a policy on providers, residents and visitors suffering from, or exposed to, infections and required actions to prevent exposure to others while infectious. Staff and visitors suffering from infectious diseases are advised not to enter the facility. Residents suffering from infectious diseases are isolated promptly to minimise the risk of spread.

Evidence is seen that the infection control programme is reviewed annually.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)
The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)
Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)
There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Stage one: Policy includes a job description for the infection control coordinator which states they have a range of skills, expertise and resources necessary to achieve the requirements of the standard.

The infection control co-ordinator verifies there are enough human, physical and information resources to implement the infection control programme and meet Fairview Care's needs. The infection control coordinator facilitates the implementation of the infection control programme as evidenced by data collection records and action plans, completed audits and competency assessments. Resources are on-site to prevent infections and manage outbreaks and include in-service education records of infection control training for staff.

Infection control training for the infection control co-ordinator occurs via training offered through external services and services offered by the WDHB. The infection control team have access to records, diagnostic results (eg, information from laboratory and the GP) to ensure timely treatment and resolution of infections.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Stage one: Policies and procedures sighted reflect current accepted good practice and meet relevant legislative requirements. A comprehensive suite of policies, procedures and information appropriate to the level of care offered is available to all staff.

Policies and procedures include, but are not limited to; hand hygiene, standard precautions (risk to all, designed to protect staff, protective clothing when in contact with body fluids, cough etiquette), transmission-based precautions (management of, isolation, protective clothing), prevention and management of infections in service providers (assessment, exposure management issues, immunisation and placement), antimicrobial usage, outbreak management (investigation and management of suspected

outbreaks), cleaning, disinfection, sterilisation and reprocessing of reusable medical devices and equipment, single use items and renovations and construction (risk of airborne infection created by environmental disturbances).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. Service providers receive orientation and ongoing education on infection control that is relevant to their practice, as verified by education records and staff interviews. The content of the infection control education sessions is documented, evaluated to ensure the content is pertinent, and a record of attendance is maintained, as sighted.

Staff report on interview that they attend infection control in-service education sessions annually. Residents and relatives report they are aware of infection control requirements should there be an outbreak.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Surveillance data collection is clearly described in policy. It states every infection is reported on an infection report form. This information is collated monthly and reviewed and analysed by the infection control coordinator who will advise management of the outcome. Management support is available to ensure infection control requirements are met.

Corrective action plans as a result of analysis of data are developed, discussed with staff, and implemented. Follow-up, as required, is completed through comparisons. Staff report that they are made aware of any infection control issues at staff meetings or at hand over if required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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