

# Oceania Care Company Limited - Elmswood Home

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Current Status: 15 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Partial Provisional 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

Elmswood Home is currently providing dementia level care in an 18 bed dementia unit. The service provider is proposing to open an another 20 bed dementia unit in what was previously a rest home wing and this audit is undertaken to establish the level of preparedness of the provider to provide this newly configured service. The facility is operated by Oceania Care Company Limited.

Three areas were identified as requiring improvement during this audit relating to evidence of food safety education having been completed by the cook, the absence of a documented preventative maintenance plan including evidence of electrical testing and tagging of all electrical items and the adequacy and safety of the external area adjacent to the dining room.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Elmswood Home
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Partial Provisional Audit
<b>Premises audited:</b>	Elmswood Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 15 July 2014 <b>End date:</b> 15 July 2014

### **Proposed changes to current services (if any):**

Currently providing dementia services in an 18 bed unit. Reconfiguration of services to increase the capacity of dementia beds from 18 to 38 beds by incorporating the remaining 20 rest home beds into another dementia unit area within this facility. There will be two separate dementia units at Elmswood Home.

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	17
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## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	8.5	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXXXXX	<b>Total hours on site</b>	8.5	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	2.5

## Sample Totals

Total audit hours on site	17	Total audit hours off site	11.5	Total audit hours	28.5
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Number of residents interviewed		Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed		Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	25	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

## Declaration

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

I confirm that:

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

Dated Monday, 28 July 2014

## Executive Summary of Audit

### General Overview

Elmswood Home is currently providing dementia level care in an 18 bed dementia unit. The service provider is proposing to open an another 20 bed dementia unit in what was previously a rest home wing and this audit is undertaken to establish the level of preparedness of the provider to provide this newly configured service. The facility is operated by Oceania Care Company Limited. Three areas were identified as requiring improvement during this audit relating to evidence of food safety education having been completed by the cook, the absence of a documented preventative maintenance plan including evidence of electrical testing and tagging of all electrical items and the adequacy and safety of the external area adjacent to the dining room.

### Outcome 1.2: Organisational Management

Oceania Care Company Limited is the governing body and is responsible for the service provided at Elmswood Home. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Elmswood Home including regular monthly reporting by the business and care manager who was appointed in August 2013 to manage this facility and another Oceania facility across the road. The business and care manager is a non-clinical manager and they are supported by a clinical leader. The service provider is currently recruiting for a clinical manager who will oversee clinical care provided at this facility and the other Oceania facility across the road.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise is occurring. In-service education is provided at least weekly for staff and staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the 'Oceania Certificate in Residential Care'. A review of staff records provides evidence that human resource processes are being followed, orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two health care assistants. The clinical leader is on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work. The business and care manager has developed a staff roster that will be implemented in stages as residents are admitted to the proposed second dementia unit.

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

There is an appropriate medicine management system in place, that complies with respective legislation, regulations and guidelines. Staff responsible for medicine management have attended in-service education for medication management and have current medication competencies. The medicine charts sampled demonstrate residents' photo identification, medicine charts are legible, as needed (PRN) medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines were dated and signed by the GP. There are no residents' who self-administer medicines.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. The menu has been reviewed by a dietitian. Food is prepared at Melrose Park, which is another Oceania facility across the road and delivered to the facility. Visual inspection and food service at Melrose Park kitchen and Elmswood satellite kitchen were conducted.

There are areas identified as requiring improvement around food safety training for kitchen staff and kitchen surfaces to comply with infection control requirements.

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

The reconfiguration of services at Elmswood Home (Elmswood) consists of refurbishing an existing 20 bed rest home area for use by residents assessed as requiring dementia level care. This 20 bed unit has two wings each with 10 beds. Security locks have been installed on three doors in this newly configured area. A new wooden fence has been installed in two separate areas to create out door areas for residents to use. Improvements are required to the external veranda area adjacent to the residents' dining room as this area is small and because of the way the fence and veranda seating have been constructed residents can potentially climb the wooden fence.

All 20 bedrooms provide single accommodation and some have ensuite facilities. There are also adequate toilet and shower facilities in each wing in this unit.

Residents' rooms are large enough to allow for residents to safely move around in them. There is a lounge and a dining room in this unit. Residents also have access to a lounge area in the existing 18 bed dementia unit. An appropriate call system is available and security systems are in place.

There are policies and procedures for waste management, cleaning, laundry and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities in both units, safe storage of chemicals and equipment and that protective equipment and clothing is provided and is used by staff

### Outcome 3: Infection Prevention and Control

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control. Interview with the clinical leader confirms there is an infection control co-ordinators' (ICC) role with a position description.

The delegation of infection control matters throughout the organization is clearly documented. There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems. The IC programme was last reviewed in February 2014.

### Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	13	0	2	0	0	0
<b>Criteria</b>	0	32	0	3	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	35
<b>Criteria</b>	0	0	0	0	0	0	0	66

### Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current	PA Low	i) There is no evidence of food safety training for the chef at Melrose Park.	Provide evidence food safety training is completed for all staff and storage shelves	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		legislation, and guidelines.		ii) The vegetable storage room shelves in Melrose Park kitchen do not comply with infection control requirements.	in Melrose Park kitchen are constructed from material that can be easily cleaned and complies with infection control requirements.	
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Electrical checks of equipment have not been conducted for all equipment required. There is no preventative maintenance plan for this facility	Provide evidence of electrical testing of all equipment and a preventative maintenance plan for the facility.	180
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Low	The deck area may pose a security risk.	Provide evidence that the external deck area off the dining room is secure and is safe for residents.	Prior to occupancy

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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:**

Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Elmswood Home. The Oceania quality and risk management systems were implemented at Elmswood Home and the documented scope, direction, goals, vision, values, mission statement and philosophy are reviewed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems for monitoring the service provided at Elmswood Home including regular monthly reporting by the business and care manager (BCM) and the clinical leader (CL) to Oceania support office via the Oceania intranet are in place. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators. Monthly business status reports are provided to the Oceania executive team and link to the organisations business plan.

The BCM is an experienced health manager and has been in this position since August 2013. The BCM also manages Melrose Park which is another Oceania facility in Tauranga. The BCM, who is not a registered nurse, is supported in their role by a clinical leader (CL) who was appointed to this position in January 2013. The CL and BCM are also supported by an acting care manager (CM) who is based at Melrose Park and who oversees care provided at both Elmswood Home and Melrose Park. They are also supported by an Oceania clinical and quality manager as well as a regional business operations manager from Oceania. The CL has a current practising certificate. The BCM advises they are currently recruiting a full time CM. The BCM and CL's CVs and personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Elmswood Home is currently certified to provide rest home level care and has contracts with the district health board (DHB) to provide aged related residential care (rest home and dementia), aged respite care and day programme for older people. During this audit there are 17 residents assessed as requiring dementia rest home level care in the existing 18 bed dementia area. The area that was used for 20 rest home residents has been decommissioned and refurbished to accommodate another 20 residents who are assessed as requiring dementia level care. The BCM advises that the existing 18 bed unit and the

proposed 20 bed unit will be staffed independently of each other and run as two separate units. The BCM advises they want to open this new unit on 04 August 2014.

The district health board contract requirements are met

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

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

**Attainment and Risk:** FA

**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:**

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the business and care manager (BCM), the clinical leader (CL) and/or the acting clinical manager (CM) be absent. At present the acting CM relieves the BCM if they are absent and the CL relieves the acting CM when they are absent. There are also two other registered nurses employed: one works three days a week and the other works two days a week. These two registered nurses are currently working from Monday to Friday as is the CL. The CL is on call after hours if required and additional clinical support/advice is available from registered nurses at Melrose Park if required.

Additional support and assistance is provided by other personnel from Oceania support office as required. Services provided meet the specific needs of the resident group within the facility. Job descriptions and interviews of the BCM and CL confirm their responsibility and authority for their roles.

The district health board contract requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical leader (CL) is currently providing oversight of the in-service education programme at Elmswood Home. During interview the BCM advises that the yet to be appointed clinical manager (CM) will ultimately have responsibility for the education programme.

The BCM advises an annual education plan is developed that is based on the Oceania education plan and that in-service education sessions are provided at least once a week. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania Certificate in Residential Care programme and the eight health care assistants (HCAs) currently working in the dementia unit have completed the dementia specific unit standards. The BCM also advises that an additional eight staff that either used to work at Elmswood Home but moved to Melrose Park during the refurbishment, or are currently working at Melrose Park and are transferring to Elmswood Home when the new dementia area opens, have completed the dementia specific unit standards.

Staff are required to attend the compulsory Oceania education sessions each year to progress through the Oceania career pathway programme. In-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2013 and 2014.

The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (five of five) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed.

Two of two health care assistants interviewed working all three shifts and two registered nurses (RNs) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

There is a documented rationale (Interim Staffing Policy) for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff that is currently provided is during the night shift and consists of two health care assistants (HCAs). A proposed roster and transition plan for staffing the new 20 bed dementia unit is reviewed that indicates on opening day there will be at least one HCA on each shift in the new unit. The transition plan states that when occupancy increases to six to eight in the new area and depending on resident acuity that a second HCA will be provided on each of the three shifts. This plan states that when resident numbers reach 12, an additional HCA will be provided on the morning shift.

There are currently three registered nurses working at Elmswood Home. The clinical leader/registered nurse works full time Monday to Friday, one of the other registered nurses works three days a week and the other works two days a week. The two part time registered nurses provide cover from Monday to Friday and there is no registered nurses working at the facility on Saturday and Sunday. The BCM advises they have reviewed the roster and registered nurse cover will be provided Monday to Sunday inclusive when the new roster is implemented. This roster is reviewed and indicates RNs will be working Monday to Sunday inclusive.

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Family members (five) interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**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 1.3.12: 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:**

The medication area in the facility evidences an appropriate and secure medicine system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug storage is secure. The controlled drug register is maintained and evidences weekly checks and six monthly stocktakes. The medication fridge temperature checks are conducted and recorded.

There are 11 staff competent to administer medicines (three registered nurses and eight health care assistants). All staff authorised to administer medicines have current competencies, sighted in staff files sampled and on staff competency register. A medication round was observed and evidences staff are

knowledgeable about the medicine administered and sign off, as the dose is administered. Additional staff competencies are conducted and these include: insulin administration; oxygen administration; nebuliser use, sighted on competency register.

Medication errors are recorded and communicated to Oceania support office on monthly basis, confirmed by the clinical and quality manager. Quality leader, registered nurse (RN) interview confirms medication competency assessment are conducted annually. Staff education in medicine management was conducted in May 2014, by a pharmacy staff member.

Ten medicine charts are sampled and demonstrate residents' photo identification, medicine charts are legible, as required medication is clearly identified for individual residents, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. Residents' medicine charts list all medications a resident is taking (including name, dose, frequency and route to be given). Standing orders are current. Staff signature log is completed. There is one GP providing medical services to the facility. There are no residents at the facility who self-administer medicines.

Sighted medication audit conducted in January 2014, with the corrective actions addressed. Controlled drugs pharmacy audit was conducted by the pharmacist in February 2014 with 100% compliance. Facility health check including medication check was conducted by the clinical and quality manager in April 2014 with corrective actions addressed.

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Food service policies and procedures are appropriate to the service setting with a new seasonal menu being introduced six monthly. Food is cooked at Melrose Park (Oceania facility located across the road from Elmswood rest home) and delivered in hot boxes to the Elmswood satellite kitchen. Lunch time food service is observed. The menu was last reviewed by a dietitian in March 2014.

Interviews with the chef and the kitchen manager at Melrose Park confirm awareness of Elmswood residents dietary requirements. Residents' dietary sheets are located at Melrose Park for kitchen staff's reference. A visual board in the Melrose Park kitchen records the Elmswood residents' dietary needs.

Interview with a kitchen hand at Elmswood rest home confirms awareness of residents' dietary preferences and food allergies. Residents' dietary requirements are identified, documented and reviewed on a regular basis, as part of the care plan review, confirmed at clinical leader interview. There are current copies of residents' dietary profiles in the Elmswood satellite kitchen, sighted. Staff files of three kitchen staff (one chef and two cooks) at Melrose Park are reviewed for food safety training and evidence two of three have food safety training. Sighted evidence of food safety training for the Elmswood kitchen hand.

Five of five family interviewed are satisfied with the food service provided, report residents' individual preferences are catered and adequate food and fluids are provided.

In the Melrose Park kitchen and Elmswood satellite kitchen food temperatures are recorded, sighted. Melrose Park kitchen fridge, chiller and freezer temperatures are recorded and decanted food is dated, sighted.

Food services audit at Elmswood was conducted in May 2014 and corrective actions addressed. A family satisfaction survey was last conducted in March 2014, with meal service response at a satisfactory level. A kitchen services audit at Melrose Park was conducted in December 2013 and April 2014, with corrective actions addressed.

There are areas identified as requiring improvement around food safety training for staff and kitchen surfaces to comply with infection control requirements. The district health board contract requirements are not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is one chef, two cooks and nine kitchen hands employed at Melrose Park. Food is transported in hot boxes to Elmswood and served to residents from a satellite kitchen, observed. Three staff files (one chef and two cooks) in Melrose Park are reviewed in respect of staff education and training in food safety. The chef's file does not evidence food safety training. Kitchen hands have completed circle of safety training, provided by Ecolab. The kitchen hand interviewed at Elmswood has food safety training, sighted.

Visual observation of Melrose Park kitchen evidences vegetable storage room shelving does not meet infection control requirements.

**Finding:**

- i) There is no evidence of food safety training for the chef at Melrose Park.
- ii) The vegetable storage room shelves in Melrose Park kitchen do not comply with infection control requirements.

**Corrective Action:**

Provide evidence food safety training is completed for all staff and storage shelves in Melrose Park kitchen are constructed from material that can be easily cleaned and complies with infection control requirements.

**Timeframe (days):** 180 (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:**

There are documented processes for the management of waste and hazardous substances in place. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available and are reviewed in the sluice room. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in March 2014. This finding is confirmed during interviews of domestic staff and review of staff education records.

Monthly visits are made by the chemical supplier representative who reviews the cleaning and laundry processes in place at Elmswood Home well as the main laundry and kitchen at Melrose Park, which is another Oceania facility in Tauranga, where all laundry and food services are provided from.

Sluice facilities are available in the existing wing as well as in the new wing for the disposal of waste and hazardous substances. A visual inspection of both wings provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and is being used by staff. For example, face shields, gloves, aprons, footwear and masks are viewed in the sluice rooms, soiled laundry storage area and in the cleaners' room.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled and the container is appropriate for the contents including container type, strength and type of lid/opening.

The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**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:** PA Low

**Evidence:**

The maintenance person interview confirms there is a reactive maintenance programme in place and regular building inspections according to the service /maintenance inspection sheets for the building warrant of fitness requirements. There is no recorded evidence of a preventative maintenance plan that

includes external areas and equipment. The maintenance person confirms they are employed full time between Melrose Park and Elmswood home. Medical equipment checks were conducted by an external contractor in January 2014. There is safe storage of medical equipment, sighted.

Building Warrant of Fitness expires 3 May 2015.

Corridors are wide enough to allow residents to pass each other safely. Safety rails are secure and are appropriately located. Floor surfaces/coverings are appropriate to the resident group and setting.

Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment; for example hoists competency. This was confirmed at four of four clinical staff interviews (two registered nurses (RN)s and two health care assistants) and review of staff education records.

There are areas requiring improvement around preventative maintenance plans, electrical checking and safe external areas.

The district health board contract requirements are not fully met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

Medical equipment checks are current. There is a reactive maintenance programme in place. Electrical checks of equipment are not current for some equipment sighted. There is no recorded evidence of a preventative maintenance plan for the facility.

**Finding:**

Electrical checks of equipment have not been conducted for all equipment required. There is no preventative maintenance plan for this facility

**Corrective Action:**

Provide evidence of electrical testing of all equipment and a preventative maintenance plan for the facility.

**Timeframe (days):** 180 (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:** PA Low

**Evidence:**

There are two external areas. One external area located by the lounge is comprised of: a cobblestone area (approximately 10 metres wide); a pathway (approximately three metres wide); and gardens and lawns either side of the pathway (taking this area to a total of approximately seven metres wide). Management and clinical leader interviewed confirm there are alternate external areas in the existing wing of the facility that may be used for the residents.

The second external area is a deck extending from the dining room. The deck is approximately six metres by five metres. The deck is surrounded by a fence. Permanent seating is situated within one metre of the fence. This design / layout may enable residents to climb over the fence.

**Finding:**

The deck area may pose a security risk.

**Corrective Action:**

Provide evidence that the external deck area off the dining room is secure and is safe for residents.

**Timeframe (days):** Prior to occupancy *(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:**

Bedrooms provide single accommodation and have wash hand basins. Several of the bedrooms have their own ensuite and there is an adequate number of communal toilet and shower facilities. The bathroom facilities are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals, sighted.

All toilets have appropriate access for residents and are clearly identified. Communal bathroom facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in these areas.

The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Visual inspection evidences that adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

Visual inspection evidences adequate access is provided to a lounge, providing seating for up to 13 residents. The dining room provides seating for up to 20 residents. Management and clinical leader interviewed confirm there are alternate areas available in the existing wing of the facility and these will be utilised. The district health board contract requirement is 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:**

Cleaning policy and procedures and laundry policy and procedures are available as well as policies and procedures for the safe storage and use of chemicals / poisons.

All laundry is washed at Melrose Park (Melrose) which is another Oceania facility and laundry facilities at Melrose are reviewed during this audit. Soiled linen is stored appropriately until it is transported in a van to Melrose for washing. Soiled linen is currently being collected twice a day and transported to Melrose in a van twice a day. The business and care manager advises during audit that the frequency of this will be increased as the resident occupancy increases. There is good dirty / clean flow and laundry personnel interviewed describe the management of laundry including transportation, sorting, storage, laundering, and return to residents. Clean linen is stored in a linen room and is stocked up daily from the laundry at Melrose.

Visual Inspection provides evidence that cleaning and laundry processes are implemented. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and monthly visits from the chemical company representative. Reports from the chemical company representative and completed audits for the laundry and cleaning are sent to the business and care manager. Cleaning staff are interviewed and they describe the management of the cleaning processes including the use of personal protective equipment.

Visual inspection of the facility provides evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas.

Relatives interviewed state they are satisfied with the cleaning and laundry service. This finding is confirmed during review of completed family / resident satisfaction surveys completed in March 2014.

The district health board contract requirements are met

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

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

**Attainment and Risk:** FA

**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 D15.3j; D19.6

**Attainment and Risk:** FA

**Evidence:**

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification are sighted. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

The business and care manager advises during interview that the fire evacuation scheme remains unchanged as result of this reconfiguration of services to convert 20 existing rest home beds in to a 20 bed secure dementia unit. Correspondence between the Oceania development manager, who is the project manager, and the local authority is reviewed concerning the installation of new electronic locks to three doors is reviewed. This correspondence indicates that the local authority “can exempt that work from the need to obtain building consent...” A producer statement for this work is also reviewed that states “electrically locked emergency-door-overrides (three total) that ensure occupants are able to leave the building in the event of an emergency...” have been installed.

A New Zealand Fire Service (NZFS) letter dated 02 September 2013 is sighted advising the fire evacuation scheme is approved. The last trial evacuation was held on 22 January 2014 and the next one is scheduled for 18 July 2014.

Registered nurses, health care assistants working night shift and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training and review of a roster confirms this. A competency spreadsheet is reviewed and the three registered nurses, one diversional therapist and six health care assistants have current first aid certificates.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Emergency management training was last provided in November 2013.

Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility provides evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; and oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facility provides evidence that emergency lighting, torches, gas and BBQ for cooking, emergency food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets, and cell phones are available.

A call bell system is in place and is used to summon assistance if required. Sensor mats are also used in some resident's bedrooms. Call bells are accessible / within reach, and are available in resident areas (e.g. bedrooms, ablution areas, ensuite toilet/showers).

The district health board contract requirements are met.

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

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

**Attainment and Risk:** FA

**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:**

Visual inspection evidences each room is provided with adequate natural light. Ventilation is by opening windows and doors. The environment is maintained at a comfortable temperature. There are heat pumps providing heating in hall ways and the dining room. Residents' rooms do not have heating provided. The business and care manager states if required heaters will be provided for residents. Management state there are no residents who smoke at the facility. Family interviewed confirm the facility (existing unit) is maintained at an appropriate temperature. The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control (IC) policy meets the needs of the organisation and provides information and resources to inform the service providers on infection prevention and control, confirmed at staff interviews. Interview with the clinical leader confirms there is an infection control co-ordinators' (ICC) role with a position description, sighted. The ICC was unavailable for interview on day of audit.

The delegation of infection control matters throughout the organization is clearly documented. There is documented evidence the governing body receives regular reports on infection related issues by regular reporting systems. The IC programme was last reviewed in February 2014.

The district health board contract requirement is met.

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

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

**Attainment and Risk:** FA

**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.)*

**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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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