# Patrick Ferry House Limited

## Current Status: 14 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

Patrick Ferry House Limited is operated by a company who operate another aged residential care facility in Auckland. Patrick Ferry House is certified to provide hospital and rest home level care for up to 74 residents. On the day of the audit there were 58 hospital residents and nine rest home residents at the premises with one rest home resident away in hospital. All beds at the facility are approved as dual-purpose beds.

Since the previous audit the facility manager has resigned and a new manager has been appointed who has yet to start in the role. The new facility manager is currently managing the company’s sister hospital. On the day of audit the facility was being managed by the General Manager who was acting in the role. One of the two clinical nurse coordinators has resigned since the last audit and the other clinical nurse coordinator has been appointed as the clinical nurse leader. She now covers both floors with support from registered nurses and health care assistants. The changes in management have been positively received by staff and residents. There is continuous registered nurse cover across all shifts. Staff consider they are well supported by management. Staff turnover is considered to be average for the Auckland area. There are developed and implemented systems and policies to guide appropriate quality care for residents. An induction programme and in-service training programme are in place that provide staff with appropriate knowledge and skills to deliver care.

There are improvements required around the incident management, consumer complaints management, the recording of reference checking of new staff, medicines management, documentation of resident’s medical conditions and hot water hazards.

## Audit Summary as at 14 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 |
|  | 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 14 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 14 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 14 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 14 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 14 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 14 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 14 July 2014

### Consumer Rights

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on residents’ rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. There is an improvement required around complaints resolution. Residents, family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around notifying families of incidents.

### Organisational Management

There is a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to monthly staff and health and safety/infection control meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and through annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. There are improvements required around completion of the incident process and completing of corrective action plans following internal audits. Incidents are collated monthly and reported to facility meetings. There are job descriptions for all positions that include the role and responsibilities of the position. A two yearly in-service training programme is in place and staff are supported to undertaken external training. There is an improvement required around reference checking prior to staff employment. The service has a documented rationale for determining staffing levels. Health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

### Continuum of Service Delivery

There are policies and procedures in place to ensure that residents’ assessed needs and goals are documented and monitored in an ongoing manner. Plans of care are developed and maintained by registered nurses and overseen by the clinical manager with input from the physiotherapist, activities coordinators and external specialist advisors (e.g. the community dietitian). Plans are developed in consultation with residents and where appropriate their family/whānau. Evaluations of plans of care occur within weeks of admission, three monthly and six monthly, or as required. Residents are reviewed three monthly or earlier if their health status changes by a general practitioner who services all residents who live at the facility. Improvements are required to the contracted medical service. The service employs three part-time activities coordinators. A range of group and individual activities are provided on both floors during the week. The activities programme is well established and enjoyed by residents. The service has its own ten-seat mini bus, which is used for outings.

The service has policies and procedures in place to guide staff at each stage of medicines management. All staff administering medication are assessed for competency. Most medicines are administered by registered nurses. Improvements are required around medication management.

Food is prepared onsite in a purpose built kitchen. Kitchen staff have completed food handling certificates. Residents with special dietary needs have their needs reviewed six monthly as part of the care planning process and these needs are identified in their care plans. Special equipment is available. The main meal of the day is served at lunch time at the request of the residents. Their preferences are monitored at the resident meetings. Residents and family interviewed were complimentary about the food service.

### Safe and Appropriate Environment

The building has been purpose built within the last few years and is built over three levels. Aged residential care is provided on two levels (the ground floor and the 1st floor) on one side of the building with services and parking being located in the basement level. The other side of the building currently contains 38 private apartments and is operated as a retirement village. All rooms are single occupancy with full disability friendly ensuites. Some rooms have ranch sliders to the exterior and others have access to a deck area. Each room has an electric hospital bed except for one room where the resident has chosen to use their own bed. The building has a current building warrant of fitness and an approved fire evacuation scheme. There are a number of communal areas spread throughout the two floors for socialisation and relaxation. There is a dining room on each level, which is linked to the kitchen by a dumb waiter system. Food is kept hot in bain maries. All laundry is done on site by dedicated staff and cleaners are employed to clean every day. There are implemented policies for the management of waste and hazardous substances, cleaning, laundry, fire and emergency management. There is a civil defence kit and alternative means of cooking. The kitchen stocks at least a week of food for use in an emergency. The property is video monitored 24 hours a day and there are security gates which are closed after dark. Improvements required to hot water hazards were addressed during the audit. Residents and relatives interviewed were very complimentary about the building and its features.

### Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. A number of residents require restraint for their safety. There are no enablers currently in use. Staff are trained in restraint minimisation.

### Infection Prevention and Control

There is an appropriate infection prevention and control programme in place. The infection prevention and control co-ordinator is the clinical manager who is responsible for coordinating the programme throughout the year. She has attended external training and has access to specialist advice. There are a suite of infection prevention and control policies, and procedures in place to guide staff. Appropriate education of staff occurs. Information obtained through the surveillance programme is used to determine infection control activities within the facility.

# 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:** | Patrick Ferry House Limited |
| **Certificate name:** | Patrick Ferry House Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Patrick Ferry House | | | |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 14 July 2014 | **End date:** | 15 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:** | 67 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 16 | **Hours off site** | 10 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 16 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 50 | Number of relatives interviewed | 8 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand 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 and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Wednesday, 13 August 2014

## **Executive Summary of Audit**

**General Overview**

Patrick Ferry House Limited is operated by a company who operate another aged residential care facility in Auckland. Patrick Ferry House is certified to provide hospital and rest home level care for up to 74 residents. On the day of the audit there were 58 hospital residents and nine rest home residents at the premises with one rest home resident away in hospital. One hospital level resident was fully funded by ACC and one rest home resident was receiving respite care. All beds at the facility are approved as dual-purpose beds.

Since the previous audit the facility manager has resigned and a new manager has been appointed who has yet to start in the role. The new facility manager is currently managing the company’s sister hospital. On the day of audit the facility was being managed by the General Manager who was acting in the role. One of the two clinical nurse coordinators has also resigned since the last audit and the other clinical nurse coordinator has been appointed as the clinical nurse leader. She now covers both floors with support from registered nurses and health care assistants. The changes in management have been positively received by staff and residents. There is continuous registered nurse cover across all shifts. Staff consider they are well supported by management. Staff turnover is considered to be average for the Auckland area. There are developed and implemented systems and policies to guide appropriate quality care for residents. An induction programme and in-service training programme are in place that provide staff with appropriate knowledge and skills to deliver care.

There are improvements required around the incident management, consumer complaints management, the recording of reference checking of new staff, medicines management, documentation of resident’s medical conditions and hot water hazards.

**Outcome 1.1: Consumer Rights**

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on residents’ rights including advocacy services. There is a Maori Health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. There is an improvement required around complaints resolution. Residents, family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time. There is an improvement required around notifying families of incidents.

**Outcome 1.2: Organisational Management**

There is a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to monthly staff and health and safety/infection control meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at two monthly meetings and through annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. There are improvements required around completion of the incident process and completing of corrective action plans following internal audits. Incidents are collated monthly and reported to facility meetings. There are job descriptions for all positions that include the role and responsibilities of the position. A two yearly in-service training programme is in place and staff are supported to undertaken external training. There is an improvement required around reference checking prior to staff employment. The service has a documented rationale for determining staffing levels. Health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

**Outcome 1.3: Continuum of Service Delivery**

There are policies and procedures in place to ensure that residents’ assessed needs and goals are documented and monitored in an ongoing manner. Plans of care are developed and maintained by registered nurses and overseen by the clinical manager with input from the physiotherapist, activities coordinators and external specialist advisors (eg: the community dietitian). Plans are developed in consultation with residents and where appropriate their family/whānau. Evaluations of plans of care occur within weeks of admission, three monthly and six monthly, or as required. Residents are reviewed three monthly or earlier if their health status changes by a general practitioner who services all residents who live at the facility. Improvements are required to the contracted medical service. The service employs three part-time activities coordinators. A range of group and individual activities are provided on both floors during the week. The activities programme is well established and enjoyed by residents. The service has its own 10 seated mini bus, which is used for outings.

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Food is prepared onsite in a purpose built kitchen. Kitchen staff have completed food handling certificates. Residents with special dietary needs have their needs reviewed six monthly as part of the care planning process and these needs are identified in their care plans. Special equipment is available. The main meal of the day is served at lunch time at the request of the residents. Their preferences are monitored at the resident meetings. Residents and family interviewed were complimentary about the food service.

**Outcome 1.4: Safe and Appropriate Environment**

The building has been purpose built within the last few years and is built over three levels. Aged residential care is provided on two levels (the ground floor and the 1st floor) on one side of the building with services and parking being located in the basement level. The other side of the building currently contains 38 private apartments and is operated as a retirement village. All rooms are single occupancy with full disability friendly ensuites. Some rooms have ranch sliders to the exterior and others have access to a deck area. Each room has an electric hospital bed except for one room where the resident has chosen to use their own bed. The building has a current building warrant of fitness and an approved fire evacuation scheme. There are a number of communal areas spread throughout the two floors for socialisation and relaxation. There is a dining room on each level, which is linked to the kitchen by a dumb waiter system. Food is kept hot in bainmaries. All laundry is done on site by dedicated staff and cleaners are employed to clean every day. There are implemented policies for the management of waste and hazardous substances, cleaning, laundry, fire and emergency management. There is a civil defence kit and alternative means of cooking. The kitchen stocks at least a week of food for use in an emergency. The property is video monitored 24 hours a day and there are security gates which are closed after dark. Improvements required to hot water hazards were addressed during the audit. Residents and relatives interviewed were very complimentary about the building and its features.

**Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. A number of residents require restraint for their safety. There are no enablers currently in use. Staff are trained in restraint minimisation.

**Outcome 3: Infection Prevention and Control**

There is an appropriate infection prevention and control programme in place. The infection prevention and control co-ordinator is the clinical manager who is responsible for coordinating the programme throughout the year. She has attended external training and has access to specialist advice. There are a suite of infection prevention and control policies, and procedures in place to guide staff. Appropriate education of staff occurs. Information obtained through the surveillance programme is used to determine infection control activities within the facility.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 43 | 0 | 6 | 1 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 6 | 1 | 0 | 0 |

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

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The documentation of one incident, which was a medication error, did not demonstrate that family were informed. | Ensure that all incidents are reported to family according to policy. | 90 |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Three of the 18 complaints reviewed did not have documented evidence that appropriate follow-up action had been taken in a timely manner. | Ensure that all complaints have appropriate documented follow-up action in a timely manner. | 60 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | One audit in October 2013 (recreational) and one audit in December 2013 (medication administration) have documented corrective action plans but here is no documented evidence that these corrective actions have been addressed and signed off. Six incident forms reviewed did not show evidence of review of corrective actions and sign off by the hospital manager. | Ensure that all corrective action reports following audits show documented evidence that corrective action plans have been addressed. Ensure that all incidents have documented evidence of review and sign off by the hospital manager. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.3 | The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Two health care assistants employed in September and October 2013 did not have documented evidence of reference checks. | Ensure that all staff have reference checks prior to employment. | 60 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The GP had not seen a person admitted for respite care within two days of admission or by the day of audit and two residents who were not considered stable by the facility GP had not been seen monthly. | Ensure newly admitted residents are seen within two working days of admission unless admitted from hospital, and ensure residents who are not considered medically stable are seen by a GP at least monthly until the GP considers them medically stable and records this opinion in their medical records. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The existing medicines management policies and associated procedures do not meet the Medicines Care Guides for Residential Aged Care.  Controlled drugs are not checked weekly by two staff and recorded in red in the Controlled Drugs Register.  Photos of residents are not named or dated.  Verbal orders are not being signed by the GP within 2 working days.  There is one resident who has been admitted for respite care who is self-administering medicines and has yet to be seen by the GP. | Ensure the medicines management policies and associated procedures comply fully with the Medicines Care Guides for Residential Aged Care.  Ensure controlled drug stocktakes occur weekly by two staff and are recorded in red in the Controlled Drugs Register.  Ensure the photos of residents used for medicine management are named and dated according to the Medicine Care Guides.  Ensure the management of patients on warfarin actively involves the GP in determining and charting dosages.  Ensure verbal orders by the GP are signed within two working days.  Ensure that the resident who is self-administering her medicines is seen by the facility GP, has her medicines charted and that the chart indicates she is self-administering her medicines. | 30 |
| 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 1.4.2.4 | The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | There are three burn hazards in the environment that residents can access (i.e., two hot water dispensers and a Bain Marie in the upstairs kitchen). These were addressed during the audit and included on the hazard register. | Ensure that the physical environment minimises the risk of harm to residents. | 30 |

## **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:**

There is a code of rights policy in use. Staff (five health care assistants, one registered nurse (RN), clinical manager and the acting hospital manager interviewed) are aware of consumer’s rights and are able to describe how they incorporate consumer rights within their service delivery. The Code of Health and Disability Services Consumers’ Rights (the Code) is discussed at resident’s two monthly meetings. The last meeting was held 15 May 2014 at which Right 1 of the Code was discussed (sighted in the minutes). The Code is part of the orientation package for staff and in-service training for staff on the Code was held in March 2014 as part of the professional development day. Residents and family believe staff respect the rights of residents (confirmed in interview with nine of nine residents (two rest home and seven hospital) and eight of eight family members (two rest home and six hospital)). Code of rights training includes advocacy, informed consent, privacy and elderly abuse and is included as part of the mandatory training days that staff undertake (last training was held in March 2014).

##### **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:**

There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility. On entry to the service residents receive an information pack that includes a code of rights information and a service agreement. Large format and Maori information is also available. On interview all staff (five health care assistants, one registered nurse (RN), clinical manager and the acting hospital manager) stated that they take time to explain the rights to residents and their family members. Nine of nine residents (two rest home and seven hospital) and eight of eight family members (two rest home and six hospital), confirmed that they had received information about their rights on entry to the service.

The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service the clinical manager or an RN discuss the information pack with the resident and the family/whānau. This includes the code of rights, complaints and advocacy. On interview nine of nine residents and eight of eight family members were able to state their understanding of the code of rights.

Health and disability advocacy service leaflets are on display on the notice board in the foyer and throughout the facility including the family room. A brochure advertising the service is also included in the information pack provided to new residents. The service can access local Maori advisory services should this be requested. Education on advocacy services is provided in the facilities self-directed learning package.

D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission information

##### **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:**

Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All nine residents and eight family members interviewed indicated staff were highly respectful and maintained resident’s privacy especially when discussing personal issues and that personal belongings are not used as communal property. Privacy training as part of code of rights training is part of the facilities professional development days held in March 2014.

The resident’s initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly. All nine residents interviewed stated their needs were met. All nine resident files reviewed, have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed could confirm this.

There is a policy that describes resident’s spiritual care. There are various churches locally and residents are encouraged to attend these. Church services are conducted in the facility every Sunday. All residents and family members interviewed indicated that resident’s spiritual needs are being met when required. On interview nine of nine residents (two rest home and seven hospital), stated staff respect their rights. There is currently one married couple resident in the facility. Couples have appropriate information in their care plans regarding staff giving them time together and privacy. The service includes emotional wellbeing in the care planning process.

Resident preferences are identified during the admission and care planning processes and family involvement is documented. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered and discussed openly. On interview all nine residents stated they are regularly consulted by staff about their care and preferences and feel this promotes their independence. On interview all five health care assistants described how they encouraged residents to engage in activities in the facility and to link with community activities including church and support groups and the RSA.

There is a policy that describes abuse and neglect and the topic is covered at orientation and has been addressed at staff meetings. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues. Abuse and neglect training is part of the professional development days that staff undertake. This was held in January 2014. Discussions with staff identified that there have been no episodes of abuse of neglect at the facility. Nine residents and eight family members interviewed were complementary of the care provided and stated staff are very approachable and friendly.

D3.1b, d, f, i: The service has a philosophy that promotes recognition of individual resident’s needs, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

D4.1a :Resident files reviewed identified that cultural, spiritual values and individual preferences are identified.

##### **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:**

The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policies/procedures.

Staff training includes cultural safety at orientation. There is presently one resident who identifies as Maori although this resident has no specific cultural preferences except to be treated with respect. Patrick Ferry House identifies cultural safety issues for Maori and can manage these on an individual basis. The service is able to access Maori advisors as identified in the Maori health policies.

Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the RN, with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual’s service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with one registered nurse, the clinical manager and five health care assistants confirm that they are aware of the need to respond to cultural differences. On interview all staff were able to identify how to obtain support so that they could respond appropriately.

A3.2: There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e).

D20.1i: The service has developed a link with the Awataha Marae.

##### **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:**

The service has established cultural policies aimed at helping meet the cultural needs of its residents. There is a Maori health plan. All residents interviewed reported that they are satisfied that their cultural and individual values are being met.

Residents and or family are involved in assessment and the care planning process (confirmed in interview with nine of nine residents (i.e., two rest home and seven hospital) and eight of eight family members (two rest home and six hospital)). Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery.

Currently all residents at the service are English speaking. On interview all staff (i.e., five health care assistants, one registered nurse (RN) and the clinical manager), confirmed awareness of interpreter services if required.

D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs

D4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. Five health care assistants (five rest home/hospital), one registered nurse and one clinical manager and the acting hospital manager (general manager) interviewed were able to describe appropriate boundaries between staff and residents and their families.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of 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:**

The service has policies to guide practice that align with the health and disability services standards. There is a quality framework that is being implemented that supports an internal audit programme. The health care assistants are encouraged to complete Careerforce NZQA level training and an internal in-service training programme is implemented. The acting hospital manager and clinical manager attend external training sessions appropriate for their positions.

The service has recently reviewed the clinical structure to enhance clinical care, staff support and improve communication. The service now has a clinical manager (replacing two clinical coordinators) and has employed a new hospital manager that is a registered nurse (due to start in August 2014). The service is in the process of introducing a number of quality initiatives (July 2014-Juy 2016) which includes (but not limited to) the following;

1.Falls programme to reduce the number of falls by 20% by December 2014 and increase resident’s assessment by 80% by March 2015

2. Reduce pressure injury rates by 20% by January 2015 and increase resident assessment of pressure injury risk by 80% by March 2015.

3. 100% of medication errors will be reported using the medication error form when identified within 24 hours by December 2014. Reduce medication errors by 99% by March 2015.

4. 99% of all complaints will be investigated and responded to within 24-48 hours by August 2014 and reduce the number of complaints related to clinical care by 20% by October 2014.

5. Introduction of visual quality notice boards for residents and staff displaying quality data.

6. Increase attendance of residents and/or families to the multidisciplinary meetings.

7. Implement advanced care planning and ensures all registered nurses are trained in the programme by July 2016.

8. Clinical manager, registered nurses and hospital manager to be trained in InterRAI by December 2014.

9. Increase resident individual activity plans and implement the activities annual plan by December 2014.

10. Implement general satisfaction survey and food services surveys by February 2015.

11. Implement quality improvement models such as plan, act, study, do cycle. Participate in “first do no harm” project with WDHB December 2015.

12. Support and achieve registered nurses to complete professional portfolios and engage in WDHB PDRP by July 2015. Establish a PDRP policy for registered nurses by July 2015.

13. Review and implement update health care assistances job description and performance appraisal process by July 2015.

14. Computerise all clinical documents and registered nurses to utilise the computer technology to complete clinical documents by January 2015.

A2.2: Services are provided at the facility that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3: All approved service standards are adhered to.

D17.7c: There are implemented competencies for registered nurses and enrolled nurses. There are clear ethical and professional standards and boundaries within job descriptions.

##### **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:** PA Low

**Evidence:**

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Eleven incidents/accidents forms were viewed (five from the ground floor and six from the first floor) for May 2014. The form includes a section to record family notification. Ten from 11 forms reviewed indicated family were informed. One incident (medication error) did not evidence that family were informed. This is an area requiring improvement. Patrick Ferry House has an open disclosure policy. On interview nine of nine residents (two rest home and seven hospital), eight of eight family members (two rest home and six hospital), and five health care assistants all stated that family are informed following changes in the resident’s health status.

The one registered nurse and the clinical manager interviewed stated that they record contact with family/whanau in resident’s files. Contact records were documented in all nine resident files reviewed.

A residents/relatives meeting occurs two monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan.

There is a policy that describes the availability of interpreter services when required.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Eight of eight family members interviewed stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents

##### **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:** PA Low

**Evidence:**

Accident/incidents, complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Eleven incidents/accidents forms were viewed (five from the ground floor and six from the first floor) for May 2014. The form includes a section to record family notification. Ten of 11 forms reviewed indicated family were informed.

**Finding:**

The documentation of one incident, which was a medication error, did not demonstrate that family were informed.

**Corrective Action:**

Ensure that all incidents are reported to family according to policy.

**Timeframe (days):** 90 *(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:**

There are implemented policies/procedures for choices and informed consent and staff encourage residents to make decisions about their care as appropriate (observed and confirmed in discussions with the clinical manager, a registered nurse, five of five health care assistants, two activities coordinators, and the physiotherapist). There are written consents in resident files (confirmed in review of sample of nine of nine clinical records (two rest home and seven hospital).

Admission agreements are signed on or before the day of their admission unless admitted directly from hospital.

Informed consent processes are discussed and implemented with residents and family or representatives (confirmed in interview with nine of nine residents (i.e., two rest home and seven hospital) and eight of eight family members (two rest home and six hospital)).

Residents are informed about their choice to make an advanced directive and there was evidence of advanced directives on resident’s records.

Staff are aware of advance directives where these are in place and rhesus status is included in the shift handover process.

D3.1d; Residents are involved in the consent process where they can make an informed choice.

D11.3; The consent form is easy to read and understand.

D12.2 & D 13.1; Residents sign their admission agreement or if not able, the Agreement is signed by their representative. The Agreement is based on the NZ Aged Care Association’s agreement template and contains consents.

##### **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:**

There is an advocacy policy. Staff receive training on advocacy services. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with five health care assistants, nine residents and eight family members informed they are aware of advocacy and how to access an advocate.

D4.1d: Discussion with eight of eight family members (two rest home and six hospital), identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks.

##### **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 be involved in community activities and maintain family and friends networks. On interview all staff (five health care assistants, one registered nurse (RN) and the clinical manager) stated that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. The facility engages with other local facilities that provide similar services.

D3.1h; Discussion with eight family members stated that they are encouraged to be involved with the service and care.

D3.1.e: Discussion with all staff and eight of eight family members (two rest home and six hospital), confirm that they are supported and encouraged to remain involved in the community and external groups such as church and RSA visits.

##### **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:** PA Low

**Evidence:**

A complaints process is in place. The complaints procedure is provided to residents and relatives at entry both in writing and verbally (evidenced in interviews with the acting hospital manager (general manager), clinical manager, the registered nurse and the cook). There are complaints forms available in multiple places throughout the facility including the dining rooms. Consumer feedback is actively sought and welcomed by management. Documentation relating to complaints is held in the complaints folder, which serves as the complaints register. The complaints register for 2014 documents a number of complaints both verbal and written including eight in January, 15 in February, 21 in March, 13 in April, 13 in May and five in June. All complaints in May and June (18) were selected for review. Fifteen of the 18 complaints reviewed had documented evidence that appropriate follow-up action had been taken in a timely manner. This is an area requiring improvement.

Residents and family are provided with information on complaints and understand the complaints process (confirmed in interview with nine of nine residents (i.e., two rest home and seven hospital) and eight of eight family members (two rest home and six hospital)).

D13.3h: A complaints procedure is provided to residents with the information pack at entry.

##### **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:** PA Low

**Evidence:**

A complaints process is in place. The complaints procedure is provided to residents and relatives at entry both in writing and verbally (evidenced in interviews with the acting hospital manager (general manager), clinical manager and registered nurse). Documentation relating to complaints is held in the complaints folder, which serves as the complaints register. The complaints register for 2014 documents a number of complaints both verbal and written including eight in January, 15 in February, 21 in March, 13 in April, 13 in May and five in June.

**Finding:**

Three of the 18 complaints reviewed did not have documented evidence that appropriate follow-up action had been taken in a timely manner.

**Corrective Action:**

Ensure that all complaints have appropriate documented follow-up action in a timely manner.

**Timeframe (days):** 60 *(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:**

Patrick Ferry House is certified to provide rest home level and hospital level care for up to 74 residents. The service is privately owned. Patrick Ferry House’s philosophy of care believes that each client is a unique person who possesses his or her own individual physical, psychological, emotional, spiritual and cultural needs. Respect of these needs is a major cornerstone of the services care. There is a current business plan and a quality and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The current business plan service goals include: a) maintaining 98% or higher occupancy, b) achieve three year certification, c) resident and family satisfaction of services, d) maintain low staff turnover, e) reduce agency costs, f) find more avenues to promote the service and g) find other ways to supplement income.

The quality process being implemented includes an internal audit programme and a health and safety programme that includes hazard management. All policies at the service have been recently been reviewed (2014) and regular review of policies has been incorporated in the document review policy. Monthly staff meetings and health and safety/infection control meetings discuss key components of the quality system and any issues are reported (minutes viewed). There is an internal audit schedule that aligns with the business plan and is implemented and a corrective action plan used to manage shortfalls.

The service has recently had an organisational change due to the resignation of the hospital manager and a clinical coordinator. The service now has a clinical manager who was previously one of the clinical coordinators and has been employed at the service for three years. The service has appointed and a new hospital manager (registered nurse) from a sister facility due to commence the position in August 2014. Currently the acting hospital manager of Patrick Ferry House is the organisations general manager. She has been with the company for eight years and has been the general manager for four years. She has a degree in information technology with a background in customer services. The general manager oversees two facilities and reports monthly to the board. The board consists of three directors of which the general manager is one of them. The hospital manager reports monthly to the general manager. The acting hospital manager is currently supported by the clinical manager who is an RN and a stable workforce. The acting hospital manager and the clinical manager share on-call duties. The clinical manager is always available on call for clinical issues. Job descriptions for the hospital manager and clinical manager positions outline their authority, accountability and responsibility.

ARC,D17.3di (rest home), D17.4b (hospital): The acting hospital manager has completed on-going training appropriate to her position including attending all of the New Zealand Aged Care Association conferences since 2009. The last one attended was May 2013. She has also attended a workshop on health information and privacy in May 2014 and has a current first aid certificate. There is RN cover in the facility 24/7.

##### **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:**

In the absence of the acting hospital manager the clinical manager oversees the management of the service. When the new hospital manager (registered nurse) commences the position the general manager of the organisation oversees the management of Patrick Ferry House in her absence with clinical support from the clinical manager.

D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies and quality improvement programme includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

##### **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:** PA Low

**Evidence:**

The facility has a quality framework that is being implemented. The acting hospital manager is directly involved in operations at the facility and the clinical manager supports her in this role. There is a current business plan that includes objectives/goals and a quality plan which includes internal audit, incident collation, infection surveillance and hazard management. Interviews with all staff (five of five health care assistants, one registered nurse (RN) and the clinical manager) inform an understanding of the quality activities undertaken at Patrick Ferry House.

The service has a quality plan (July 2014-July2016) which focuses on quality outcomes including; enhance patient safety, improve systems and processes, improve resident and/or family engagement, optimize the residents experience, and clinical quality excellence. As part of the quality plan and to enhance patient safety the service has implemented a post falls review for each resident who has had a fall. The service also employed an external contractor to review the process who reported that the service is fulfilling post falls documentation and three recommendations are in the process of being actioned (April 2104).

Resident meetings occur two monthly (minutes viewed). All nine residents interviewed are aware meetings are held. Annual satisfaction surveys are undertaken. The last satisfaction survey was held in July 2013 and the service received 46 responses from residents and relatives. There was overall satisfaction with medical, nursing, recreational, catering, cleaning, laundry and reception services. All residents and relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.

D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans.

D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g: Falls prevention strategies such as physiotherapy reviews, instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The acting hospital manager and the clinical manager are managing quality systems. There is a quality team which includes the acting hospital manager, clinical manager (infection prevention coordinator and restraint coordinator) and the health and safety representatives including healthcare assistant, registered nurse, kitchen, cleaning, and maintenance staff. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff meetings and health and safety/infection control meetings. Meetings discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety.

Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. A sample of 11 incidents/accidents from May 2014 were reviewed (five from the ground floor and six from the first floor). The facilities policy and procedure on incident management were implemented for five of 11 incident forms sampled. This is an area requiring improvement. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. Patrick Ferry House has 10 residents with 11 restraints. There are no enablers currently in use.

There is a 2014 internal audit programme which includes all aspects of service delivery which includes (but not limited to): safe handling (January), restraint (January), continence (March), medicine management (March), complaints (April), falls incidents (April), documentation (April), practicing certificates (April), incident and accident reporting (May), foodservices and kitchen compliance (July) and cleaning (July). All issues found in the 2013 audits have identified corrective action plans. One audit in October 2013 (recreational) and one audit in December 2013 (medication administration) have documented corrective action plans but there is no documented evidence that these corrective actions have been addressed and signed off. This is an area requiring improvement. Results of audits are discussed in health and safety/infection control and staff meetings.

Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to health and safety/infection control and staff meetings. Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. All staff interviewed could describe the corrective action process.

Patrick Ferry House has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be well utilised. Five health care assistants interviewed are aware of hazard reporting.

##### **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:** PA Low

**Evidence:**

There is a 2014 internal audit programme which includes all aspects of service delivery which includes (but not limited to): safe handling (January), restraint (January), continence (March), medicine management (March), complaints (April), falls incidents (April), documentation (April), practicing certificates (April), incident and accident reporting (May), foodservices and kitchen compliance (July) and cleaning (July). All issues found in the 2013 audits have identified corrective action plans.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. A sample of 11 incidents/accidents from May 2014 were reviewed (five from the ground floor and six from the first floor). The facilities policy and procedure on incident management were implemented for five of 11 incident forms sampled.

**Finding:**

One audit in October 2013 (recreational) and one audit in December 2013 (medication administration) have documented corrective action plans but here is no documented evidence that these corrective actions have been addressed and signed off. Six incident forms reviewed did not show evidence of review of corrective actions and sign off by the hospital manager.

**Corrective Action:**

Ensure that all corrective action reports following audits show documented evidence that corrective action plans have been addressed. Ensure that all incidents have documented evidence of review and sign off by the hospital manager.

**Timeframe (days):** 90 *(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:**

There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the clinical manager, who monitors issues. The incident forms are then reviewed for comment/summary by the hospital manager and signed off (# link 1.2.3.8). If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to the staff meetings and quality meetings.

Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.

A sample of 11 incidents/accidents from May 2014 were reviewed (five from the ground floor and six from the first floor). The facilities policy and procedure on incident management were implemented for five of 11 incident forms sampled. Six incident forms reviewed did not show evidence of review and sign off by the hospital manager (#link 1.2.3.8).

D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

##### **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:** PA Low

**Evidence:**

There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. All staff have employment contracts. The practising certificate of registered nurses is current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist (sighted). Appointment documentation is seen on file for eight staff files sampled (one clinical manager, two registered nurse, three health care assistants, one cook and one cleaner/kitchen assistant) including signed contracts, orientation, annual performance appraisals and training. One of eight staff files sampled had documented evidence of reference checks (cook employed from sister facility). Two health care assistants employed in September and October 2013 did not have documented evidence of reference checks. This is an area requiring improvement.

There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation (sighted in all eight of eight files reviewed as outlined above and confirmed in interviews with five of five health care assistants and the registered nurse). Staff have a period of supervision when employed and health care assistants reported that supervision can be extended if needed. The service has a training policy and schedule for in-service education. The inservice schedule is implemented and attendance recorded at sessions kept. The service has introduced professional development days which cover all key training requirements. Interviews with five of five health care assistants inform there is access to sufficient training. Medication competencies are completed for all registered nurses and staff who administer medication. These are checked by the clinical manager.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, wounds, restraint, diabetes/insulin administration and syringe driver use.

##### **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:** PA Low

**Evidence:**

There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. All staff have employment contracts. The practising certificate of RN’s is current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist and physiotherapist (sighted). Appointment documentation is seen on file for eight staff files sampled (one clinical manager, two registered nurse, three health care assistants, one cook and one cleaner/kitchen assistant) including signed contracts, orientation, annual performance appraisals and training. One of eight staff files sampled had documented evidence of reference checks.

**Finding:**

Two health care assistants employed in September and October 2013 did not have documented evidence of reference checks.

**Corrective Action:**

Ensure that all staff have reference checks prior to employment.

**Timeframe (days):** 60 *(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:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All family members and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the clinical manager or the acting hospital manager (general manager) will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff.

There is a registered nurse on duty at all times.

A contractor physiotherapist attends the facility for four hours a week plus as required.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).

All resident files are hard copy files. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated and include allied health professional, specialist and GP input and reviews (# link 1.3.3.1). The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home, and hospital service level setting. The service keeps a resident register.

Patrick Ferry House has a control of documents and records process that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy resident files are stored securely and protected from unauthorised access by being held at the nurses’ stations in a secured cupboard. Old files are individually archived and locked in a secure area for 10 years

Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel.

Care plans and progress notes are legible, signed and dated by the staff member recording the information. Medical notes and allied health input are signed and dated appropriately.

D7.1: Entries are legible, dates and signed by a registered nurse or health care assistant including designation.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a pre entry admission policy which clearly describes entry criteria to the service. Residents are assessed prior to entry to the service by the NASC agency. Calls for admission are handled by the facility manager and then passed to the clinical manager for consideration. Pre-entry forms are completed. The facility is open during normal operation hours. Doors are secured during hours of darkness. There are no restrictions of visiting times (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital). The service has an information pack available for residents/families/whanau at entry. The information pack includes all relevant aspects of the service and residents and or family/whanau are provided with associated information.

A13.2d; Information to residents is contained in the Admission Agreement, which is based on the NZ Aged Care Association’s template.

D11.1; D11.2: An entry pack of information is given to prospective residents and their families(confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)..

D13.3; D13.4; The admission agreement reviewed aligns with a) -k of the ARC Agreement.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

##### **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:**

Declining entry to the service is included in the pre- entry policy. The process includes informing the referrer and the family/advocate/whànau of the reason for the decision to decline. When a prospective resident is declined access to the service they are informed of alternative services available to them. Prospective residents would be referred back to the original referrer for other options that may assist them to meet their needs and the process is documented. The clinical manager reports that they have not declined anyone who has been referred as usually discussions occur with the Needs Assessment Service Coordination (NASC) prior to any referral being made by the NASC.

##### **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:** PA Low

**Evidence:**

Registered nurses are responsible for undertaking the assessments on admission and activity assessments and individual activities care plans have been completed by the activities coordinators (confirmed in review of sample of nine of nine clinical records and in discussions with the clinical manager, a registered nurse, five of five health care assistants, two activities coordinators). The physiotherapist assesses each resident for mobility needs (confirmed in discussion with the physiotherapist and in review of the above nine of nine clinical records).

D16.2, 3, 4; Nine residents files were reviewed. In all nine of nine files, the initial admission assessments and plans were completed by registered nurses within 24 hours and the long term care plans were completed by the registered nurses within a three week timeframe.

D16.5e; Medical assessments were documented in within 48 hours of admission where the person had not been admitted directly from hospital. One person admitted for respite care had not been seen by the facility GP since she was admitted at the end of June 2014. The GP (interviewed) prefers to see residents monthly or more frequently unless she considers them medically stable. Medical reviews were documented by the GP in the residents’ files. Two residents had not been noted as medically stable by the GP in their medical records and had not been seen for three months. The GP and the clinical manager are aware of the need in the Agreement for the GP to record the term “stable” in the resident’s medical records. There was evidence of frequent medical assessment and reviews occurring in residents records with many residents seen monthly. The GP typically attends the facility twice a week. She works independently servicing aged residential care facilities in the area and is not able to visit the facility every day of the week due to her other commitments. Management are working on a solution to better meet the needs of residents.

Initial data gathering and assessments include but are not limited to; demographic details, baseline observations, goals, problems, allergies, personal care needs (including a head to toe assessment, pain management, sleeping routines, cultural and spiritual needs, behaviours, cognitive ability, mobility, dietary needs including food likes and dislikes. Nursing assessment tools completed on entry to the service include; incontinence assessments, Coombe assessment tools for falls, Braden Scale for pressure sores, pain assessments and assessments of any challenging behaviour (confirmed in review of sample of nine of nine clinical records.

The clinical manager and five of five health care assistants confirm that a verbal handover occurs at the end of each duty and a handover form is used (which doubles as the fire list if evacuation if necessary). The handover ensure that continuity of service delivery occurs. All care staff attend the handovers which happen when the shifts changeover.

Nine residents (two rest home and seven hospital) stated that overall the care was good and the staff were very caring and respectful. Eight relatives (two rest home and six hospital) reported that the care is very good.

Tracer Methodology: rest home resident:

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

Tracer Methodology: hospital resident:

*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:** PA Low

**Evidence:**

One person was admitted for four weeks of respite care at the end of June 2014 and had not been seen by the facility GP to date, and two residents had not been noted as medically stable by the GP and had not been seen monthly by the GP. The GP is aware of the need in the Agreement to record the term “stable” in the resident’s medical records if she intends to see them three monthly. She relies on nursing staff to bring to her attention the need to review a resident.

**Finding:**

The GP had not seen a person admitted for respite care within two days of admission or by the day of audit and two residents who were not considered stable by the facility GP had not been seen monthly.

**Corrective Action:**

Ensure newly admitted residents are seen within two working days of admission unless admitted from hospital, and ensure residents who are not considered medically stable are seen by a GP at least monthly until the GP considers them medically stable and records this opinion in their medical records.

**Timeframe (days):** 90 *(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:**

An initial assessment is completed by registered nurses on entry followed by the development of the resident’s care plan (confirmed in discussion with the clinical manager and confirmed in review of sample of nine of nine clinical records.

Initial data gathering and assessments are completed within 24 hours of admission. Initial data gathering and assessments include but are not limited to; demographic details, baseline observations, goals, problems, allergies, personal care needs (including a head to toe assessment, pain management, sleeping routines, cultural and spiritual needs, behaviours, cognitive ability, mobility, dietary needs including food likes and dislikes. Nursing assessment tools completed on entry to the service include; incontinence assessments, Coombe assessment tools for falls, Braden Scale for pressure sores, pain assessments and assessments of any challenging behaviour (confirmed in review of sample of nine of nine clinical records. Assessments and intervention information is shared with the residents and their families as appropriate. Following the assessment process a long term care plan is developed, which includes goals, intervention and evaluation. This plan is developed within three weeks of admission.

Residents and families report that individual needs and preferences are discussed (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital).

D 16.2: Each resident is assessed on admission by a registered nurse.

##### **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:**

D16.3b: An initial care plan is commenced on admission and a long term plan is developed within three weeks of (confirmed in review of sample of nine of nine clinical records. Health care assistants’ report that the plans are easy to understand (confirmed in discussions with five of five health care assistants who work across all shifts and provide care to both rest home and hospital level residents).

D16.3f: Residents and family have an opportunity to contribute to the plans of care (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital).

D16.3g, h,I,j,: the Plan addresses the resident’s current abilities.

D16.3k: Short term plans are used when relevant. Short term care plans are well utilised in the rest home and hospital. Short term care plans were sighted for Pain management UTI, Lower and Upper Respiratory Tract Infections, Other infections, Other reasons. There is a separate wound book with wound management records that link long term care plans. Neuro observations and long term management is managed differently on different forms.

##### **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:**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes ((confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital).

Care plans are completed by registered nurses (confirmed in discussion with the clinical manager and a registered nurse (RN)). Care delivery is recorded and evaluated by health care assistants and registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, a GP or specialist consultation. The Community Dietitian visited one resident who was being PEG fed. She confirmed during interview that the clinical manager had initiated her visit as the resident had been noted to be gaining weight. The community dietitian changed the PEG feeding regime to ensure the resident could maintain a stable weight.

Staff have access to sufficient equipment to provide the care specified in care plans (confirmed in discussions with the clinical manager, one RN, and five of five health care assistants (who work in all areas). Equipment necessary to provide care, includes hoists, wheelchairs, continence supplies, dressing supplies and any miscellaneous items. There are adequate continence and dressing supplies available (confirmed by observation and in discussions with the clinical manager, the RN and five of five health care assistants).

There is a falls prevention-reducing harm policy in place, which is comprehensive and was last reviewed April 2014. All residents are assessed for their falls risk on admission. There are strategies in place to reduce falls. Strategies include the employment of a physiotherapist who works with the residents on an as needs basis and provides advice to care staff (physiotherapist interviewed). The physiotherapist’s advice is recorded on the handover sheet. Restraint is used as a strategy of last resort. The policy includes a post fall protocol that includes neurological observations if indicated. There is documented evidence of falls management occurring.

Residents and relatives were very complimentary of care received at the facility (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)).

D18.3 and 4 Dressing supplies are available and a treatment room is well stocked for use. Wound assessment and wound management plans are in place for 19 residents, which includes five residents with pressure areas (consisting of Grade1 (1), Grade 2 (2), Grade 3 (2) and 14 residents with minor wounds.

The clinical manager is able to access specialist nursing advice and has good access and feels well supported by the Waitemata DHB specialist nursing teams, including the Wound Nurse Specialist Waitemata DHB.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available, as needed.

Continence management in-service was last provided April 2014 and wound management in-service was last provided December 2013.

The facility has registered nurse cover 24 hours a day, seven days a week.

During the tour of facility it was noted that all staff treated residents with respect and dignity.

D16.1a &.1b.i: Residents are orientated to the facility on entry.

D16.5a; Routines in the facility reflect community norms

D18.3: Dressing supplies are provided.

D18.4: Continence supplies are provided.

##### **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:**

The service employs three activities coordinators who all work part-time in the role (two were interviewed). One activities coordinator is employed 27 hours a week, another is employed 10 hours a week and the third is employed 15 hours a week. Two of the three activities coordinators are in the process of completing diversional therapy qualifications and the other is enrolled to study for the qualification. The three activities coordinators are in the process of arranging contacts with other diversional therapist working in the area for peer support and inspiration. The service employed an external diversional therapist part-time to review the activities programme and to recommend improvements, which happened around eight months ago.

A personal profile sheet is completed for residents on admission to establish past and present interests. The service records interests, family, values/beliefs, likes/dislikes, personality, culture and spirituality and other information.

A range of activities are provided, which includes activities such as: physical (eg, chair exercises, walking inside (as the premises are on a hill), walking in parks areas and the beach following van rides), bowls, quoits, balloon games ball games) and there is physiotherapist who is employed to work with people. Cognitive activities include quiz games, crosswords, housie, board games, newspapers, cards, dominoes, and puzzles. Social activities include van trips to parks, beaches, restaurants, cafes, movies, and concerts. The group programme includes arranging entertainers to visit the premises (eg, school children come and sing, concerts, guitar players, piano players, Glenfield entertainers, and pets are bough in through the SPCA). There is a “Happy Hour” held every Friday after lunch. Spiritual needs are accommodated by an interdenominational service which is held every third Thursday once a month. A Christian fellowship group visits the facility once a week on Sundays. Some residents are visited by their own visiting priest. Other residents will attend church services with their family. Activities involve family and the wider community.

The facility has one minivan, which is not hoist capable. The van seats 10 residents in the back and two staff including the driver. The van has kiddie locks. If a hoist capable van is needed the facility hires a mobility van. The facility offers twice weekly bus trips in the summer months and once to twice weekly in the winter months, which are dependent on weather.

Residents (and their relatives) were observed enjoying activities. The activities coordinators report that many hospital residents just enjoy their individual programme. The most popular individual activity for women is spending time with the activities coordinator having beauty therapy and for men they tend to like sharing their life histories with the activities coordinator in a one on one situation.

Residents have two monthly residents meetings which are held downstairs. There is a folder of minutes in both lounges. Staff report residents contribute well to the meetings. Most of the discussion is invariably on food.

Residents and relatives are very happy with the activities programmes on offer (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)).

D16.5c.iii; Each resident has a written individual activities plan which is evaluated and reviewed each time the care plan is reviewed.

D16.5d The programme includes group and individual activities.

##### **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:**

Care plans are reviewed and evaluated by the registered nurses either within three weeks of admission, six monthly or when changes to care occur (confirmed in review of sample of nine of nine clinical records (i.e., two rest home and seven hospital) and confirmed in discussions with the clinical manager)). A multidisciplinary approach to the review of care occurs. Changes to the long term lifestyle care plan are made as required and at the six monthly review if required. There are short term care plans in use which focus on acute and short-term issues.

D16.3c, All initial care plans were evaluated by the RN within three weeks of admission.

D16.3d: Care plans are reviewed by an RN where necessary.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated and residents and relatives are involved (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)).

##### **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:**

The service facilitates access to other services (eg, the wound nurse, the geriatric nurse specialist, and the community dietitian). Referral documentation is retained in resident files. A discharge record is reviewed. The clinical manager liaises with the residents' GP and the family members before the arrangements to transfer a resident are made. This is documented in the progress notes. There is a special hospital transfer package of forms that are completed prior to transferring a resident to Waitemata DHB.

D16.4c; The service provided an example of where a residents condition had changed and the resident was reassessed for a higher level of care

D 16.4d: Residents are reassessed by the NASC as needed. There are no residents waiting for reassessment currently.

D 20.1 Discussions with the clinical manager confirmed the service has access to medical advice, in-house physiotherapy, wound care advice, a community dietitian, infection prevention and control and other specialist nursing advice as needed.

D 20.4: Typically family will accompany residents to appointments or residents are transferred in ambulances with ambulance staff. Staff would accompany a resident if no family are available and the resident needed to be accompanied.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

The service has policies around transfer and discharge to facilitate safe transfer of a resident to another service. Policies are implemented. There is a formal system in place for when residents are required to be transferred to Waitemata DHB, which includes communication with all parties involved. Planned discharges are discussed in advance with the relevant agencies.

D21: There are appropriate discharge and transfer systems in place.

##### **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:** PA Moderate

**Evidence:**

There are policies and procedures for the medicines management system to guide staff. The existing policy does not meet the Medicines Care Guides for Residential Aged Care (Link 1.3.12.1) (discussed with the clinical manager). An improvement is required.

Prescribing is managed by the resident’s GP. There is only one GP for all residents (which is potentially 74 residents if the facility is fully occupied). The GP attends the facility twice a week. Management accepts that this current arrangement needs to change as the facility has a high number of hospital level residents and residents who need palliative care management following admission from hospices.

Dispensing is managed by one pharmacy and the clinical manager reports the service works well.

Administration of medicines is managed by RN's who are assessed as competent and senior health care assistants who been assessed as competent. Competency checks occur yearly. Medicine administration education was last provided in June 2014. The facility uses the robotics packed medicines for packaging of tablets and other medicines have pharmacy generated labelling on the dispensed packages or bottles. Medication administration was observed at one medication round and the process was correctly carried out. Medications and associated documentation are kept on the medication trollies which are stored in locked cupboards in the nurses’ station on both floors.

Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are not checked weekly by two staff and recorded in red in the Controlled Drugs Register, as specified in the Medicines Care Guides for Residential Aged Care (page 11). An improvement is required (Link 1.3.12.1).

The pharmacist checks controlled drugs 6 monthly and records the stock count (last checked 10 April 14).

There is a drug refrigerator in a locked cupboard in the nurses’ station. The RNs monitor the temperatures and record then on a chart above the refrigerator

Medication reconciliation is completed on admission and the policy includes guidelines for checking medicines on arrival when stocks are supplied.

Resident photos and allergies are on all the drug charts. Photos of residents are not dated as specified in the Medicines Care Guides for Residential Aged Care (page 7) (Link 1.3.12.1).An improvement is required.

Disposal of medicines is managed by quarantining all medicines that need to be returned to the pharmacy. There is a pharmacy return system in place. The pharmacist picks up these quarantined medicines every week as and when they deliver new medicines.

There is one respite resident self-administering her medicines. There is a letter on her file from her current GP handing her care over to the facility GP (which has not yet happened- link 1.3.3 above). She has not been seen by the facility GP and had her medicines charted and therefore there is no order that this resident is permitted to self-administer. There is policy and procedures in place regarding residents who self-administer medicines. A self-medication assessment had been completed by a RN for this resident who is considered competent to self-administer her medicines. She has a locked safe in her room and keeps the key on her person (sighted).

Verbal medicine orders are not signed by a GP within two working days. There are forms in use that state that verbal orders do not need to be signed by a GP for seven days.

18 Medication charts were reviewed (i.e., 4 rest home and 14 hospital). There is an internal audit programme in place that includes audit of medicines management (last audit conducted April 2014 which failed to pick up the above non-compliances).

D1.1g; The system has been designed to comply with the Medicines Act. However improvements as noted above are required.

D15.3c; Medicines are stored safely. However improvements as noted above are required.

D16.5e.i.2; The GP reviews each resident’s medicines three monthly and notes and signs the medication chart (with the exception of the resident admitted for respite care).

D18.2; Medicines are provided according to the terms of the Agreement except for the exceptions noted above.

D19.2d: Medicines are managed and administered safely except for the exceptions noted above.

##### **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:** PA Moderate

**Evidence:**

There are policies and procedures for the medicines management system to guide staff which do not meet the Medicines Care Guides for Residential Aged Care.

Controlled drugs are not being checked weekly by two staff and recorded in red in the Controlled Drugs Register, as specified in the Medicines Care Guides for Residential Aged Care (page 11).

Resident photos are stuck on all drug charts. The photos of residents are not named or dated as specified in the Medicines Care Guides for Residential Aged Care (page 7).

Standing orders are in place for the GP providing services at the facility.

Verbal medicine orders are not signed by a GP within two working days.

There is one respite resident self-administering her medicines. There is a letter on her file from her current GP handing her care over to the facility GP on admission (which has not yet happened- link 1.3.3 above). She has not been seen by the facility GP and has not had her medicines charted and therefore there is no order that this resident is permitted to self-administer her medicines.

**Finding:**

The existing medicines management policies and associated procedures do not meet the Medicines Care Guides for Residential Aged Care.

Controlled drugs are not checked weekly by two staff and recorded in red in the Controlled Drugs Register.

Photos of residents are not named or dated.

Verbal orders are not being signed by the GP within 2 working days.

There is one resident who has been admitted for respite care who is self-administering medicines and has yet to be seen by the GP.

**Corrective Action:**

Ensure the medicines management policies and associated procedures comply fully with the Medicines Care Guides for Residential Aged Care.

Ensure controlled drug stocktakes occur weekly by two staff and are recorded in red in the Controlled Drugs Register.

Ensure the photos of residents used for medicine management are named and dated according to the Medicine Care Guides.

Ensure the management of patients on warfarin actively involves the GP in determining and charting dosages.

Ensure verbal orders by the GP are signed within two working days.

Ensure that the resident who is self-administering her medicines is seen by the facility GP, has her medicines charted and that the chart indicates she is self-administering her medicines.

**Timeframe (days):** 30 *(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:**

The facility has an onsite kitchen that supplies all food for the rest home and hospital residents. Food is transferred through a connecting dumb waiter to the upstairs kitchen/dining room. Residents eating in their rooms are served off a trolley with hot food covers. There is a kitchen manual in place which was last reviewed in March 2014. There are two cooks and six kitchen assistants (Main cook interviewed). One cook works Sunday to Thursdays and the other cook works Fridays and Saturdays. They cover each other as necessary. Breakfast is prepared by a kitchen assistant and the cooks prepare the lunch and tea. Supper is prepared by the tea kitchen assistant. The main meal of the day is served at lunch time, as this is the preference of the residents. Staff check meal preference times at each residents meetings and report that residents are clear on their preferences. Staff have completed food safety certificates. The four weekly menu, which covers autumn/winter and spring/summer has been reviewed by an external dietitian in April 2014. Food is ordered by the cooks against the menu. Most food is produced on site. Food is stored either in a dry store, chiller or a freezer. Food is stored off the floor and is dated, labelled, decanted and expiry dates. There is a stock list to guide purchasing. There is a chemical system in place for food waste and external person comes in daily to pick up food waste which goes out in normal waste collection. Residents’ likes and dislikes are known and documented and on display on a white board to guide staff when serving. Residents needing special equipment, or supervision at meal times is documented in the kitchen. Special equipment or preparation of food requirements are accommodated. One resident is fed by a PEG tube and her feeding regime is documented by the dietitian in her medicine records. Hats are worn in the kitchen. The kitchen has a gas hob, gas oven and electric combi ovens and microwaves. A slow cooker is used for the porridge, which is turned on by the night staff. Refrigerator, freezer and food serving temperatures are checked daily and results recorded. The kitchen stores at least 12 days of food onsite to enable it to cope in a civil defence emergency. The lunch time meal was observed. Many relatives were present participating in the meal time with residents.

Residents and relatives believe the food is very good (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)).

A food satisfaction survey is completed which was satisfactory each dining room has a supply of complaints/compliment forms to facilitate feedback. A kitchen internal audit was conducted in July 2014. The Cook reports that the new management structure is working very well. Staff receive inservice education/ PEG feeding training was provided in April 2014.

D1.1a; Food hygiene regulations are respected.

D15.2b; The food service reflects the needs of the residents.

D19.2c; Kitchen staff have attended a safe food handling course.

##### **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:**

There are policies and procedures implemented for the safe and appropriate storage including disposal of any waste including infectious or hazardous materials. There is a sluice room available on each floor, which is equipped with a washing and disposal facility and protective equipment for staff. There are specific places for the storage of cleaning chemicals, which are stored in the original manufacturer’s containers in non-public areas. Cleaners and clinical staff have access to protective equipment (eg, gloves and aprons). Training on the management of chemicals and waste occurs (last provided February 2013). An environmental audit was done in May 2014.

##### **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:**

Maintenance is performed. Reactive maintenance is logged in a book for management to action. There is a preventative maintenance programme in place. The building holds a current warrant of fitness, which expires 8 January 2015. The warrant includes the internal passenger lift. Medical equipment is calibrated (which includes the sphygmomanometers, sitting scales, hoists, hydraulic beds) (and is due November 2014). There are six hoists in use. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms are carpeted. The facility is fully equipped with electric beds in all rooms except for one rest home resident who has her own bed. It has one ‘low-low’ hospital bed and the others are ordinary hospital beds. There are hand rails to assist mobility. Residents were observed moving freely around the areas using mobility aids where required. The external areas are well maintained and gardens are attractive. There is garden furniture and shaded areas to sit. There is flat access to all areas. There is an internal audit programme in place that includes audit of building maintenance (last audit conducted May 2014).

The physical environment used by residents includes two hot water dispensers that dispense boiling water for people to make cups of tea. Residents are also able to access the dining room upstairs which has a Bain Marie that is heated prior to lunch being decanted from the downstairs kitchen. These three items are all burn hazards and were included as part of the hazard register.

D4.1b; The premises are homelike. Residents and relatives interviewed are very appreciative of the environment (confirmed in discussions with nine of nine residents (two rest home and seven hospital) and eight of eight relatives (two rest home and six hospital)).

D15.1; The premises are designed to meet the needs of the elderly (with the exception of the three hazards identified above).

D15.2a; D15.2e; D15.3; All furniture, fixtures and fittings are provided. Residents can bring their own furniture.

D20.2; D20.3; D20.4; Transport is provided. The facility has minivan, which is not hoist capable. It necessary a hoist capable mobility van is hired.

##### **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:** PA Low

**Evidence:**

The physical environment used by residents includes three burn hazards. There are two hot water dispensers that dispense boiling water for people to make hot drinks and residents are also able to access the dining room upstairs, which has a Bain Marie that is steam heated prior to lunch being transferred from the downstairs kitchen. Staff report that no resident has been harmed to date by these hazards.

**Finding:**

There are three burn hazards in the environment that residents can access (i.e., two hot water dispensers and a Bain Marie in the upstairs kitchen). These were addressed during the audit and included on the hazard register.

**Corrective Action:**

Ensure that the physical environment minimises the risk of harm to residents.

**Timeframe (days):** 30 *(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:**

The service has sufficient toilet and showering facilities to meet the need of the residents. Every room has an ensuite and all rooms have a hand basin. There is a system in place to monitor the temperatures of hot water taps in residents’ rooms. The temperature is monitored monthly and the temperatures fluctuate between 42 to 45°C. Action is taken if the temperatures are outside of the accepted range. The service has adequate hand washing facilities in common areas and there are a number of alcohol hand gel dispensers throughout the premises. Toilet and showers are identifiable and have appropriate signage when in use. There are separate toilets for staff and visitor use.

##### **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:**

Resident rooms are sufficiently large to allow for care to be provided and for the safe manoeuvring of mobility aids. Resident transfer between rooms is not required in a bed because residents who are reassessed are able to stay in their own room, as all rooms are approved as ‘swing’ rooms. An ambulance stretcher could manoeuvre within the rooms if required and can be used in the lift.

##### **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:**

The service has a number of lounges and two large dining rooms. There are areas for relaxation and activities. Residents are served meals in their rooms if that is their preference. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a way that enables residents to mobilise.

##### **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 written policies and procedures for effective management of laundry and cleaning practices. Cleaning and laundry staff have access to protective equipment including gloves and disposable aprons. Chemicals are supplied by Ecolab. Ecolab provides monitoring and training of their supplied chemicals in both the laundry and cleaning services (last training was in July 2012). Chemical safety information data sheets are available for staff to access. There is an internal audit programme in place that includes audit of the cleaning and laundry (last audit conducted May 2014).

Laundry is performed by three laundry assistants who job share every day of the week (confirmed in discussions with one laundry assistant).There is a laundry in the basement area well removed from areas that residents utilise. All of the laundry is cleaned on site. There are two commercial washers, two commercial driers, and staff have the ability to soak stained linen. The laundry is well laid out with a clean and dirty flow design. There is space to fold and store linen before it goes back out to the rooms. The laundry itself was clean and tidy, well lit and ventilated.

Cleaning is performed by dedicated cleaners who work 8.30 am to 3 pm, Monday to Sundays and each day there is one cleaner per floor (confirmed in discussions with one cleaner). The cleaners have dedicated cleaning trollies and a schedule of cleaning activities to carry out during the day. They carry out other cleaning as required. The cleaners have a locked storage cupboard on each floor to store their trolleys and cleaning chemicals. All the cleaning chemicals are stored in the original manufacturer’s containers, labelled and stored securely.

##### **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:**

Fire evacuation practice documentation exists (last occurred in February 2014 and 39 staff attended). A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence boxes are available on the ground floor and the first floor (sighted). The staff stated that they have spare blankets and alternative cooking methods if required. There is a barbeque available and the kitchen has access to gas and electricity for cooking. The service has access to a generator if required. There is sufficient water stored in four water tanks to ensure for three litres per day for three days per resident plus there is an onsite swimming pool of non-potable water. There is at least a week’s supply of food stored on site.

The staffing level provided adequate numbers of staff to facilitate safe care to rest home and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme in August 2008.

There are electronic call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week. The facility has video monitoring 24 hours a day and gates that can be secured overnight to restrict public access to the site.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

##### **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:**

The building is well designed with lots of natural light and internal atriums. All bedrooms and lounges have windows of a large size that open to the outside of the building and include security stays for safety. Many of the bedrooms have sliding doors which open out onto either an internal courtyard of a protected balcony for each room. Heating is a mix of underfloor gas and electricity. There are temperature gauges located throughout the facility to guide staff on the internal temperatures. Smoking is only permitted in one designated area by residents and staff, which is on the ground floor in a secluded area within the internal courtyard. The building is smoke free. There are no residents who smoke currently.

##### **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:**

There is a restraint policy and manual with associated procedures and templates. The policy states that the use of restraints is kept to a minimum and that care staff who may be involved in restraint and enabler use have sufficient knowledge and skill to be able to ensure resident safety.

The restraint policy and procedure includes definitions such as use of restraint, types of restraint permitted, use of enablers, enablers permitted, client rights, assessment, discussion, restraint alternatives, monitoring and removal. There is a restraint/enabler assessment form, consent form and monitoring form. Patrick Ferry House has 10 residents (hospital) with 11 restraints, which are 10 bed rails and one lap belt. The restraint policy requires that the service considers alternatives to restraint prior to any intervention. The policy also includes procedures for the use of restraint, cultural considerations, guidelines for restraint use and monitoring. On-going consultation with the resident and family/whanau is also identified.

The service identifies enablers as items which are voluntarily used for safety. There are currently no residents with enablers.

The restraints policy defines enablers as being voluntary use of equipment (eg, for safety for the resident). Restraint minimisation training was last delivered in January 2014 as part of the professional development days. Challenging behaviour and de-escalation training was also included in these days. All five of five health care assistants interviewed could describe processes around enabler, restraint and challenging behaviour practice.

The service has clear documentation to guide staff in the use of restraint and enablers. There are clear guidelines in the policy to determine what a restraint is and what an enabler is.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Consumers receive services in a safe manner.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Only staff that have completed training are permitted to apply restraints. There are responsibilities and accountabilities determined in the restraint policy that includes responsibilities for key staff. Interviews with the restraint coordinator and review of her signed job description identified understanding of the role.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family/whanau. The role of the restraint coordinator is held by the clinical manager who has been in the post for three years. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool and enabler assessment tool available and completed for the residents requiring bed rails and lap belts. The care plans are up to date and include information on assessing the risks of safety and the need for restraint. On-going consultation with the resident (when able), and family/whanau is also identified. Falls risk assessments are completed six monthly. Challenging behaviour assessment/management plans are completed as required. A restraint assessment form is completed for those residents requiring restraint. Documentation for restraints was viewed for three hospital residents who have restraints. Files included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed monthly (written evaluation sighted).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed at least three monthly within the facility restraint meeting and also as part of monthly restraint register reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. On interview the restraint coordinator stated that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and is evidenced as being implemented. Care plans reviewed of three hospital residents with bed rails and one lap belt identified observations and monitoring. All residents who have restraints are entered in the restraint register.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations have occurred at least six monthly as part of the on-going reassessment for the residents on the restraint register and as part of care plan review. Families are included as part of this review. A review of three hospital files with restraints identified that evaluations are up to date and have reviewed (but not limited to); a) whether the desired outcome was achieved, b) whether the restraint was the least restrictive option and c) the impact. Restraint is reviewed on a formal basis three monthly and monthly through restraint register review and by the facility approval team. Evaluation timeframes are determined by risk levels.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Individual approved restraint is reviewed at least six monthly through the restraint meeting and as part of the facility approval team review with whanau involvement. Restraint usage throughout the facility is analysed and information fed back to staff via all facility meetings and discussed at staff handovers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection prevention and control (IPC) processes are documented in an infection prevention and control manual. The clinical manager who is a registered nurse is responsible to the facility manager for infection prevention and control (interviewed). She has a job description that includes responsibilities on file. She has received training and experience in infection prevention and control. There is are processes in place to minimise the risk of infection to residents, visitors and staff (which includes hand gel at reception, warning signs, notices on bedroom doors, a Flu vaccination programme where vaccination is offered to both residents and staff). There is an active surveillance programme in place to minimise the risk of infection to residents, staff and visitors. The infection prevention and control policy includes the purpose of the infection control programme, designated staff responsibilities and quality and risk management strategies and responsibilities. An annual review of the programme is completed (last completed Jan 2014). Infection and prevention control issues are a fixed agenda item at the monthly staff meeting.

##### **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:**

The infection prevention and control programme is implemented by the infection control committee and all staff. The committee includes the clinical manager, a laundry assistant, a registered nurse and a health care assistant. The infection prevention and control committee has access to expertise from the facility GP, the laboratory, Waitemata DHB staff, and external advisors (eg, Bug Control and consultants). The Committee reports through the two monthly Health and Safety / Infection Prevention and control meeting where IPC is a fixed agenda item (minutes sighted May 2014).

##### **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:**

Comprehensive policies and procedures are implemented. The policies and procedures reflect current accepted good practice. Policies are accessible for staff at each nurse’s station and on the intranet (observed). The infection prevention and control coordinator is responsible for reviewing and developing infection prevention and control policies.

##### **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:**

All staff receive education at orientation and on-going refresher training (last provided March 2014). IPC is discussed at meetings (minutes sighted). The clinical manager has access to on-going education specific to IPC (last attended Waitemata DHB IPC training 2013). Consumer or family education is provided when opportunities present (eg, there is signage throughout the facility where risk exists and there are signs about hand washing.

##### **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:**

Policies are implemented for surveillance that identify what types of infections are monitored and methods used. Infections monitored include urinary tract Infections (UTI), influenza, skin infections, upper and lower respiratory tract infections and are based on standard infection definitions. Monthly surveillance activities are completed with reports and graphs generated and communicated to staff at the monthly staff meeting (documentation sighted). Infections are logged on an incident form and collated into a monthly log sheet which records the name of the resident, date, infection, specimens, results received and date, treatment, duration and follow-up. The date resolved is on individual form and short term care plans. Results are analysed, trended over time, graphed and reported at monthly staff meetings. Actions are taken depending on the nature of the infectious risk. The type of surveillance undertaken is appropriate for the size and type of aged care facility.

##### **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.)*