# Oceania Care Company Limited - Trevellyn Home & Hospital

## Current Status: 31 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

Trevellyn Home and Hospital can provide care for up to 109 residents (53 rest home specific beds, 56 hospital beds with nine beds that can be used for either rest home or hospital level care). During the audit there were 88 residents living at the facility including 43 residents at the rest home level of care and 45 residents at hospital level of care. The business, care and village manager was responsible for the overall management of the facility and has been in this role since 2009. The clinical manager, a registered nurse, provided clinical oversight and both managers were supported by the Oceania clinical and quality manager, a registered nurse. The service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

The staffing policy is the foundation for workforce planning. The staffing levels are reviewed for anticipated workloads and acuity with rosters indicating that staffing reflects resident acuity and bed occupancy. There were registered nurses on site at all times. The residents were supported by health care assistants with residents and family stating that they received a high standard of support.

The service attained a rating of continuous improvement for the provision of services that were responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each resident identified.

Improvements were required to the incident and accidents system, medications, care planning including documentation of interventions on care plans and the handover process.

## Audit Summary as at 31 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 31 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

### Organisational Management as at 31 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 medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 31 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 31 July 2014

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

### Restraint Minimisation and Safe Practice as at 31 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 31 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 31 July 2014

### Consumer Rights

The staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission.

The informed consent policy and processes are implemented by the service, meeting contractual requirements. The staff ensure residents are informed and have choices related to the care they receive.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

The service receives a rating of continuous improvement around provision of services that promote individuality and values.

### Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. There are meetings to discuss quality and risk management and business status reports. Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and an ongoing training programme. There is a policy for determining staffing and skill mix for safe service delivery. Staff identify that staffing levels are adequate and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed.

The business, care and village manager is supported by the clinical manager who has a background in aged care nursing and the Oceania clinical and quality manager who supports a number of sites.

An improvement is required to ensuring that there is discussion of incidents and accidents at all levels.

### Continuum of Service Delivery

The resident’s entry to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by suitably qualified staff who are competent to perform their role. The clinical manager or the registered nurses use standardised risk assessment tools. An information pack is provided to the resident and families on admission. The admission agreements are signed on admission by the residents or their families. Declined residents are referred back to the referrer in a timely manner to discuss other referral options. The reason for declining the entry of the resident to the service is documented.

The service has an integrated system of documentation. The general practitioner assesses new residents within 24-48 hours of admission. The person centred care plans are developed in a timely manner and reviewed by the clinical manager or the registered nurses regularly. The care plan interventions are insufficiently detailed to address the current issues identified and this requires an improvement. The multi-disciplinary reviews are conducted annually. The contents of the hand over is not comprehensive and this requires an improvement.

The activities provided by the service are appropriate to the needs of the residents.

The clinical manager facilitates residents’ access to other medical and non-medical services available for them. The referrals are made to specialist medical services as well as other allied health professionals. The assessments of the residents’ level of care are conducted by the assessment team. There is a policy for transition, exit, discharge or transfer from services. The yellow envelopes are utilised when residents are transferred to public hospital.

There are 21 medication charts reviewed with findings around transcribing, three monthly reviews, unsigned discontinued medications, allergies, signing of controlled drugs, signing the medication chart after administering medications and crushing of medications and these require improvements. The medication fridge monitoring is conducted daily. There are no expired or unwanted medications sighted during the audit. There is no resident who self-administers medicines.

A resident’s individual food, fluids and nutritional needs are met. The clinical manager or registered nurses complete a dietary requirement form, and a copy is given to the kitchen manager. There is a diet code in the kitchen board. Modified diets are provided by the service. The food handling certificates are all current. The four week rotating winter and summer menus are reviewed by the dietitian annually. The food temperatures and fridge/freezer/chiller temperatures are monitored daily. Special food and dietary requirements are arranged by the cook and the meals are well presented. The served meals are appropriate for older people and serving sizes are adequate. The kitchen is clean and there are adequate food supplies in the pantry. A cleaning schedule is conducted daily.

### Safe and Appropriate Environment

All building and plant comply with legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to hand basins and paper towels. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment.

The residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely. The laundry is completed for Trevellyn Home and Hospital and one other provider and staff monitor cleaning to ensure that the facility is spotless.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies, and first aid are included in the staff training programme. The call bell system has been upgraded and this is monitored to ensure that call bells function at all times.

### Restraint Minimisation and Safe Practice

The restraint minimisation policy and procedure are implemented by the service. The restraint register is current with 11 residents utilising restraint and one resident using an enabler. The restraint assessments, restraint consents and restraint monitoring forms are recorded. The risk management plans are in place for all 11 residents on restraint and three monthly evaluations are conducted. The clinical manager is the restraint coordinator. Staff demonstrate good knowledge about the use of restraints and enablers. All staff have current restraint competencies. Restraint in-service educations was last completed in March and April 2014. The restraint minimisation policy and procedures are reviewed last March 2013.

### Infection Prevention and Control

The infection control programme is reviewed annually and is appropriate for the service. The infection control nurse can access resources both within and outside the organisation. The infection rates are monitored and entered onto the Oceania intranet for benchmarking. The clinical manager provides guidance to the infection control nurse. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and regular meetings occur. The in-service trainings provided for all staff is conducted annually. Visitors, families and staff are reminded not to visit the facility when they are not feeling well. Hand gels are available inside the facility and there are adequate hand basins to use by staff, residents and visitors.

# 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:** | Oceania Care Company Limited |
| **Certificate name:** | Oceania Care Company Limited - Trevellyn Home & Hospital |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Trevellyn Home & Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 31 July 2014 | **End date:** | 1 August 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:** | 88 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 12 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 4 |

## **Sample Totals**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 11 | Number of staff interviewed | 12 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 10 | Number of staff records reviewed | 12 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 21 | Total number of staff (headcount) | 53 | Number of relatives interviewed | 10 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Monday, 25 August 2014

## **Executive Summary of Audit**

**General Overview**

Trevellyn Home and Hospitalcan provide care for up to 109 residents (53 rest home specific beds, 56 hospital beds with nine beds that can be used for either rest home or hospital level care). During the audit there were 88 residents living at the facility including 43 residents at the rest home level of care and 45 residents at hospital level of care. The business, care and village manager was responsible for the overall management of the facility and has been in this role since 2009. The clinical manager, a registered nurse, provided clinical oversight and both managers were supported by the Oceania clinical and quality manager, a registered nurse. The service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

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The service attained a rating of continuous improvement for the provision of services that were responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each resident identified.

Improvements were required to the incident and accidents system, medications, care planning including documentation of interventions on care plans and the handover process.

**Outcome 1.1: Consumer Rights**

The staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. The residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding consumers’ rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission.

The informed consent policy and processes are implemented by the service, meeting contractual requirements. The staff ensure residents are informed and have choices related to the care they receive.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A robust system for managing complaints is in place.

The service receives a rating of continuous improvement around provision of services that promote individuality and values.

**Outcome 1.2: Organisational Management**

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. There are meetings to discuss quality and risk management and business status reports. Benchmarking reports are produced that include incidents/accidents, infections and complaints. These are used to provide comparisons with other facilities.

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The business, care and village manager is supported by the clinical manager who has a background in aged care nursing and the Oceania clinical and quality manager who supports a number of sites.

An improvement is required to ensuring that there is discussion of incidents and accidents at all levels.

**Outcome 1.3: Continuum of Service Delivery**

The resident’s entry to the services is facilitated in a competent, equitable, timely, and respectful manner. Each stage of service delivery is undertaken by suitably qualified staff who are competent to perform their role. The clinical manager or the registered nurses use standardised risk assessment tools. An information pack is provided to the resident and families on admission. The admission agreements are signed on admission by the residents or their families. Declined residents are referred back to the referrer in a timely manner to discuss other referral options. The reason for declining the entry of the resident to the service is documented.

The service has an integrated system of documentation. The general practitioner assesses new residents within 24-48 hours of admission. The person centred care plans are developed in a timely manner and reviewed by the clinical manager or the registered nurses regularly. The care plan interventions are insufficiently detailed to address the current issues identified and this requires an improvement. The multi-disciplinary reviews are conducted annually. The contents of the hand over is not comprehensive and this requires an improvement.

The activities provided by the service are appropriate to the needs of the residents.

The clinical manager facilitates residents’ access to other medical and non-medical services available for them. The referrals are made to specialist medical services as well as other allied health professionals. The assessments of the residents’ level of care are conducted by the assessment team. There is a policy for transition, exit, discharge or transfer from services. The yellow envelopes are utilised when residents are transferred to public hospital.

There are 21 medication charts reviewed with findings around transcribing, three monthly reviews, unsigned discontinued medications, allergies, signing of controlled drugs, signing the medication chart after administering medications and crushing of medications and these require improvements. The medication fridge monitoring is conducted daily. There are no expired or unwanted medications sighted during the audit. There is no resident who self-administers medicines.

A resident’s individual food, fluids and nutritional needs are met. The clinical manager or registered nurses complete a dietary requirement form, and a copy is given to the kitchen manager. There is a diet code in the kitchen board. Modified diets are provided by the service. The food handling certificates are all current. The four week rotating winter and summer menus are reviewed by the dietitian annually. The food temperatures and fridge/freezer/chiller temperatures are monitored daily. Special food and dietary requirements are arranged by the cook and the meals are well presented. The served meals are appropriate for older people and serving sizes are adequate. The kitchen is clean and there are adequate food supplies in the pantry. A cleaning schedule is conducted daily.

**Outcome 1.4: Safe and Appropriate Environment**

All building and plant comply with legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to hand basins and paper towels. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment.

The residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Activities can occur in any of the lounges and furniture is arranged to ensure residents are able to move freely and safely. The laundry is completed for Trevellyn Home and Hospital and one other provider and staff monitor cleaning to ensure that the facility is spotless.

Essential emergency and security systems are in place with regular fire drills completed. Emergencies, and first aid are included in the staff training programme. The call bell system has been upgraded and this is monitored to ensure that call bells function at all times.

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

The restraint minimisation policy and procedure are implemented by the service. The restraint register is current with 11 residents utilising restraint and one resident using an enabler. The restraint assessments, restraint consents and restraint monitoring forms are recorded. The risk management plans are in place for all 11 residents on restraint and three monthly evaluations are conducted. The clinical manager is the restraint coordinator. Staff demonstrate good knowledge about the use of restraints and enablers. All staff have current restraint competencies. Restraint in-service educations was last completed in March and April 2014. The restraint minimisation policy and procedures are reviewed last March 2013.

**Outcome 3: Infection Prevention and Control**

The infection control programme is reviewed annually and is appropriate for the service. The infection control nurse can access resources both within and outside the organisation. The infection rates are monitored and entered onto the Oceania intranet for benchmarking. The clinical manager provides guidance to the infection control nurse. Staff are knowledgeable about infection control and prevention. The infection control committee has representatives from different areas within the service and regular meetings occur. The in-service trainings provided for all staff is conducted annually. Visitors, families and staff are reminded not to visit the facility when they are not feeling well. Hand gels are available inside the facility and there are adequate hand basins to use by staff, residents and visitors.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 1 | 45 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** | 1 | 95 | 0 | 3 | 2 | 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 1.2.3: 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.5 | Key components of service delivery shall be explicitly linked to the quality management system. | PA Moderate | There is little evidence in the 2014 meeting minutes of discussion around incidents and accidents. | Ensure that there is a forum to discuss incidents and accident data with information leading to quality improvement. | 90 |
| 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 Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is evidence documentation is not consistently provided within the time frames that safely meet the needs of the residents. | Staff to conduct assessments and document the outcome of the assessment in the resident’s clinical file. | 90 |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | The contents of the hand-over are not comprehensive to ensure continuity of care for the residents. | Contents of the hand-over must be detailed to capture vital information including antibiotics, resident’s conditions during the shift and the rationale of undertaken procedures/sampling. | 60 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The four out of ten reviewed resident’s files have interventions that are not well documented with insufficiently detailed strategies to address the desired outcome/goals of the residents. | Document interventions including strategies that will address the desired outcomes or goals. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | There are 21 medications charts reviewed with the following issues:  1. Nine out of 21 reflect transcribing of medications by staff administering medications.  2. Four out of 21 are not reviewed by the GP every three months.  3. Four out of 21 discontinued medications are not signed by the GP.  4. Two out of 21 have no allergy written.  5. There are six areas either not signed or not countersigned in the controlled drugs register. There is no incident report completed by the staff for the six medication errors sighted.  6. There are 9 unsigned areas in the signing sheets. There is no incident report completed by staff for the 9 unsigned medication areas identified.  7. The medications that require to be crushed are not recorded to a level of detail to ensure resident/patient safety. | 1. Staff must not transcribe medications; follow procedures in medicine administration including documentation and controlled drugs policies and procedures.  2. GP to review all medication charts every three months, sign all discontinued medications and write allergies in all medication charts.  3. Staff to complete incident reports for medication administration/procedural errors.  4. Medications to be crushed must be recorded in detail in the medication charts. | 30 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect | Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | CI |  |
| HDS(C)S.2008 | Criterion 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. | CI | Residents are supported by a service that is responsive to their needs, values and beliefs. Particular attention is described by staff as being paid to ensuring that staff are responsive to needs and residents supported holistically and individually.  The resident files reviewed (10 of 10) identify that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the business, care and village manager. There are weekly visits by a Catholic priest, weekly Presbyterian/Methodist church services (stated by the chaplain as being interdenominational) and a monthly Anglican Holy Communion. A family member came in at Easter time to read in the chapel to the residents and noted that a number of other residents also joined in to the service. As a result and after discussions with the business, care and village manager, there is a prayer meeting on the fifth Sunday of each month facilitated by the family member. The information has been circulated to residents through the ‘Between Us’ newsletter that also includes special thoughts and uplifting notes. The Chaplin is considered an integral member of the team and this includes weekly individual meetings with residents including people in independent living, residents in the rest home and hospital and weekly meetings with staff and the business, care and village manager. The Chaplin describes a holistic approach to health. The whole facility was blessed in December 2013 and each room is blessed by the kaumatua or Chaplin when needed (observed during the audit). The involvement in the community of the service is seen as over and above that normally provided by a spiritual advisor.  The service takes a quality improvement approach with the focus on improving the lives of the residents. There are two residents who identify as Chinese with English as a second language. Staff are available to interpret for residents and staff describe these staff being regularly accessed. One staff member converses with another Indian resident and describes frequent and daily conversations that include time outside of work. The service has a strong emphasis on engaging family. There are activities that recognise differences. The kitchen staff describe cooking food brought into the service by the family with the cost of food being reimbursed by the service. The kitchen manager and chef also prepare food in advance with this frozen so that staff can reheat food out of normal meal times. The Chaplin, residents, family and staff confirm that there is no evidence of abuse or neglect with residents and family confirming that staff go out of their way to be respectful and courteous. There is an emphasis in the staff and quality meeting minutes on ways of speaking and communicating. The development of the courtyard with guinea pigs, rabbits and birds is described by residents, family and staff as being a focal point of the facility with this triggering conversation, time to engage with family of all ages and a private space for residents to gather. The Chaplin interviewed also confirms that there is a continued positive approach to communication with a value placed on supporting residents and family with individual needs and beliefs. Eleven residents (six rest home and five hospital) and 10 family members (six hospital and four rest home) interviewed all state that they have chosen this facility as a place to be because of the warmth and approachability of staff, the willingness to respond to any complaints or concerns, the approachability of the business, care and village manager and the positive communication. Individual residents describe ways in which staff have supported them individually. One resident for example who has been in a rest home for a number of years has been supported to ‘take over’ the chaplains office and make it a welcoming space with this having a dual purpose of enabling the resident to continue to do craft activities. The conversion of five four-bedded rooms to individual bedrooms has also allowed residents to have their own space. The development of the courtyard with guinea pigs, rabbits and birds is described by residents, family and staff as being a focal point of the facility with this triggering conversation, time to engage with family of all ages and a private space for residents to gather. The Chaplin interviewed also confirms that there is a continued positive approach to communication with a value placed on supporting residents and family with individual needs and beliefs. The depth of feedback received by the audit team praising the service so consistently for the quality improvement approach with the focus on improving the lives of the residents is greater than normally provided by residents and family interviewed as part of an audit process.  Effectiveness of the spiritual care and responsiveness to needs, values and beliefs is evaluated through the resident and relative satisfaction surveys completed annually with a high level of satisfaction noted. Any improvements identified through the audit and satisfaction surveys related to personal privacy and to respect for residents have been implemented and the improvements described have been well monitored and reviewed to ensure that they are effective.  The District Health Board contract requirements are met. |

# 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:**

Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Interviews with the clinical manager, five of five health care assistants and five of five registered nurses confirm their understanding of the Code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.

The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.   
Training around the code of rights and complaints was last provided in April 2014. The auditors note respectful attitudes towards residents on the days of the audit.

The District Health Board contract requirements are met.

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

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

**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:**

A registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held during the monthly residents' meetings (meeting minutes sighted). Residents and family interviews confirm their rights are being upheld by the service. Information regarding the Health and Disability Advocacy Service is clearly displayed in multiple locations throughout the facility and in a brochure that is held at reception.  
Code of rights leaflets are available at the front entrance of the service.

Code of rights posters are on the walls in the service. If necessary, staff will read and explain information to residents as stated by the health care assistants and registered nurses interviewed.

Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.

Eleven residents (six rest home and five hospital) and ten family members (six hospital and four rest home) interviewed are able to describe their rights and advocacy services particularly in relation to the complaints process.

The District Health Board contract requirements are met.

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

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

**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:** CI

**Evidence:**

The service has a philosophy that promotes dignity and respect and quality of life.

The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people’s beliefs and values with the registered nurses and clinical manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these are identified and evaluated. The residents are addressed by their preferred name and this is documented in ten of ten files reviewed (five rest home including one resident requiring respite care and five hospital).

A policy is available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality (sexuality and intimacy) in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour. Staff have received training around sexuality and intimacy last conducted in 2012.  
The service ensures that each resident has the right to privacy and dignity, which is recognised and respected. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room.

Five health care assistants interviewed report they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents’ privacy is respected.

The health care assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available five days a week to assess and review residents with six residents stating specifically that for them this is a highlight of the service. The health care assistants assist residents with their activity programmes.

The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. They are committed to provide guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect wherever or whenever this may arise. There is an expectation that staff will, at all times, work within the organisation’s mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code as described by the business, care and village manager. Staff receive mandatory education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation. Staff interviewed are aware of the signs of abuse and neglect and have last had training around abuse and neglect in July 2014.

The resident files reviewed (10 of 10) identify that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the business, care and village manager. There are weekly visits by a Catholic priest, weekly Presbyterian/Methodist church services (stated by the chaplain as being interdenominational) and a monthly Anglican Holy Communion. On the fifth Sunday of each month, a family member is also taking a prayer meeting for any residents who wish to join in.

There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.

The District Health Board contract requirements are met.

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

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

**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:** CI

**Evidence:**

**Finding:**

Residents are supported by a service that is responsive to their needs, values and beliefs. Particular attention is described by staff as being paid to ensuring that staff are responsive to needs and residents supported holistically and individually.

The resident files reviewed (10 of 10) identify that cultural and /or spiritual values, individual preferences are identified and these are discussed as part of the monthly meetings as issues are identified as described by the business, care and village manager. There are weekly visits by a Catholic priest, weekly Presbyterian/Methodist church services (stated by the chaplain as being interdenominational) and a monthly Anglican Holy Communion. A family member came in at Easter time to read in the chapel to the residents and noted that a number of other residents also joined in to the service. As a result and after discussions with the business, care and village manager, there is a prayer meeting on the fifth Sunday of each month facilitated by the family member. The information has been circulated to residents through the ‘Between Us’ newsletter that also includes special thoughts and uplifting notes. The Chaplin is considered an integral member of the team and this includes weekly individual meetings with residents including people in independent living, residents in the rest home and hospital and weekly meetings with staff and the business, care and village manager. The Chaplin describes a holistic approach to health. The whole facility was blessed in December 2013 and each room is blessed by the kaumatua or Chaplin when needed (observed during the audit). The involvement in the community of the service is seen as over and above that normally provided by a spiritual advisor.

The service takes a quality improvement approach with the focus on improving the lives of the residents. There are two residents who identify as Chinese with English as a second language. Staff are available to interpret for residents and staff describe these staff being regularly accessed. One staff member converses with another Indian resident and describes frequent and daily conversations that include time outside of work. The service has a strong emphasis on engaging family. There are activities that recognise differences. The kitchen staff describe cooking food brought into the service by the family with the cost of food being reimbursed by the service. The kitchen manager and chef also prepare food in advance with this frozen so that staff can reheat food out of normal meal times. The Chaplin, residents, family and staff confirm that there is no evidence of abuse or neglect with residents and family confirming that staff go out of their way to be respectful and courteous. There is an emphasis in the staff and quality meeting minutes on ways of speaking and communicating. The development of the courtyard with guinea pigs, rabbits and birds is described by residents, family and staff as being a focal point of the facility with this triggering conversation, time to engage with family of all ages and a private space for residents to gather. The Chaplin interviewed also confirms that there is a continued positive approach to communication with a value placed on supporting residents and family with individual needs and beliefs. Eleven residents (six rest home and five hospital) and 10 family members (six hospital and four rest home) interviewed all state that they have chosen this facility as a place to be because of the warmth and approachability of staff, the willingness to respond to any complaints or concerns, the approachability of the business, care and village manager and the positive communication. Individual residents describe ways in which staff have supported them individually. One resident for example who has been in a rest home for a number of years has been supported to ‘take over’ the chaplains office and make it a welcoming space with this having a dual purpose of enabling the resident to continue to do craft activities. The conversion of five four-bedded rooms to individual bedrooms has also allowed residents to have their own space. The development of the courtyard with guinea pigs, rabbits and birds is described by residents, family and staff as being a focal point of the facility with this triggering conversation, time to engage with family of all ages and a private space for residents to gather. The Chaplin interviewed also confirms that there is a continued positive approach to communication with a value placed on supporting residents and family with individual needs and beliefs. The depth of feedback received by the audit team praising the service so consistently for the quality improvement approach with the focus on improving the lives of the residents is greater than normally provided by residents and family interviewed as part of an audit process.

Effectiveness of the spiritual care and responsiveness to needs, values and beliefs is evaluated through the resident and relative satisfaction surveys completed annually with a high level of satisfaction noted. Any improvements identified through the audit and satisfaction surveys related to personal privacy and to respect for residents have been implemented and the improvements described have been well monitored and reviewed to ensure that they are effective.

The District Health Board contract requirements are met.

**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 implements the Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.

Links to local kaumatua Maori services are documented and include access through the housekeeper and the clinical manager both of whom are able to describe their links in the community.

The clinical manager is engaging a kaumatua to become engaged with the service and initial meetings have occurred.  
There are two Maori residents living at the facility during this audit. There are staff members who identify as Maori including the clinical manager, housekeeper and eight health care assistants who work across all shifts.

The staff interviewed report specific cultural needs are identified in the residents’ care plans. This was further evidenced in 10 of 10 resident files selected for review (five hospital and five rest home). Staff are aware of the importance of whanau in the delivery of care for their Maori residents. Maori events are linked to the activities programme.

The District Health Board contract requirements are met.

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

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

**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 identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline.

The residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident’s cultural values and beliefs. This information is used to develop a care plan and includes input from the resident and their family (confirmed by eleven residents (six rest home and five hospital) and ten family members (six hospital and four rest home) interviewed.

There are two residents with English as a second language who communicate with each other. Staff describe ways of communicating including use of cards, sign language and use of staff and family as interpreters. Both have family who visit daily. The activities programme also notes use of games that are relevant to the culture. One resident who identifies as Pacific has a full cultural assessment and plan completed. One of the files reviewed for a resident who identifies as Chinese has also a full cultural assessment and plan completed.

The District Health Board contract requirements are met.

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

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

**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:**

The facility implements Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.

Job descriptions include responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on 12 of 12 staff files reviewed.

The orientation and employee agreement provided to staff on induction includes standards of conduct with staff signing a confidentiality form.

Interviews with staff including the diversional therapist, five health care assistants across hospital and rest home, five registered nurses and the clinical manager confirm their understanding of professional boundaries, including the boundaries of the health care assistants’ role and responsibilities.

The District Health Board contract requirements are met.

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

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

**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:**

Trevellyn Home and Hospital (Trevellyn) implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed annually. There is a quality framework that that supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.

There is an annual training programme and managers are encouraged to complete management training.

There is a monthly regional management meeting and the business, care and village manager states that there is excellent support from the regional manager and the clinical and quality manager. The business, care and village manager describes a meeting with a facility manager from a neighbouring provider in aged care that will provide peer support and the ability to discuss best and evidence based practice.

Specialised training and related competencies are in place for the registered nursing staff and for health care assistants. Twelve of twelve files sighted have annual competencies completed.

Residents and families interviewed express a high level of satisfaction with the care delivered. The general practitioner interviewed reports that a high standard of care is provided at the service.

Consultation is available through the organisation’s management team that includes clinical and quality managers, operations managers, dietitian, national training manager, national maintenance manager etc. A physiotherapist is available five days a week.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 28 of 28 completed accident/incident forms.

Family contact is recorded in residents’ files – sighted in 10 of 10 files reviewed.

Interviews with 11 residents (six rest home and five hospital) and 10 family members (six hospital and four rest home) interviewed confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member.

Family interviewed confirm that they are invited to attend the monthly resident meetings and that there is an open door policy of the clinical manager and the business, care and village manager.

Interpreter services are available when required from the District Health Board.

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

Staff have had training around communication in April 2014. Staff have had training around open disclosure last in September 2013.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. The policy determines that staff ensure all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.

All resident files identified that informed consent is collected.

Interviews with staff including the health care assistants identify their understanding of informed consent processes. They described how informed consents are sought in the delivery of personal cares including daily choices and communication and this is confirmed by residents who identify that they are able to make choices.

The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process.

The advance directive and consent policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files indicates that all have appropriately signed advance directives signed on the day of admission.

Discussion with family identifies that the service actively involves them in decisions that affect their relatives lives.

The District Health Board requirements are met.

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

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

**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:**

Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.

The diversional therapist and the chaplain are responsible for facilitating the monthly residents’ meetings and report information is regularly provided to the residents regarding their right to access advocacy services through HDC. Staff training on the role of advocacy services is included in training on The Code of Health and Disability Consumers’ Rights – last provided for staff in May 2014 facilitated by Aged Concern.

Discussions with family and residents identify that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.

The resident files include information on resident’s family/whanau and chosen social networks.

Staff including the five health care assistants interviewed are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.

The District Health Board contract requirements are met.

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

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

**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:**

The service has an open visiting policy. The residents may have visitors of their choice at any time. The facility is secured in the evenings (earlier in winter to coincide with dusk) but visitors can arrange to visit after doors are locked. Families interviewed confirm they can visit at any reasonable time and are always made to feel welcome. Family were seen coming and going freely on the days of the audit.

The residents are encouraged to be involved in community activities and maintain family and friends networks. Links are also encouraged through church with some residents still engaged in community activities including attending their own church services and going to activities in the local community. One resident describes the service as being ‘perfectly positioned ‘so that the resident can access the shopping centre, cafes etc. Residents have performing groups who entertain residents. Residents are included in shopping visits and outings with families.

The District Health Board contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation’s complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. The complaint forms are available at the entrance. A complaint register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder.

Two complaints lodged in 2013 were selected for review. There is documented evidence of time-frames being met for responding to these complaints.

All 11 residents (six rest home and five hospital) and 10 family members (six hospital and four rest home) interviewed state that they would feel comfortable complaining. One family member states that a complaint had been made and this has been addressed through the care plan review.

The business, care and village manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities. The business, care and village manager describes a culture of reporting and documenting complaints so that concerns can be dealt with efficiently.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Trevellyn Home and Hospital (Trevellyn) is part of the Oceania group with the executive management team including the CEO, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service. Communication between the service and managers takes place on a monthly basis.

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is ‘we provide excellent contemporary care that reflects our residents’ individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life’.

The facility can provide care for up to 109 residents (53 rest home beds with nine able to be dual purpose and 56 hospital beds). During the audit there are 88 residents living at the facility including 43 residents at the rest home level of care (including five identified as requiring respite care) and 45 residents at hospital level of care. There are two residents identified as under 65 years of age.

The business, care and village manager is responsible for the overall management of the facility and has been in the role since 2009. The business, care and village manager has a diploma in aged care and has completed the quadrant leadership course with Oceania. The business, care and village manager also has over 10 years’ experience in aged care in administrative roles with professional development relating to the management of an aged care facility exceeds eight hours over the past year.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the absence of business, care and village manager, a clinical manager is in charge with support from the clinical and quality manager. The current clinical manager has been employed at the service since July 2013 and has 32 years’ experience in aged care services.

The clinical manager has experience as a diabetes nurse educator and is completing a post graduate qualification. The clinical manager completes assessments for Maori residents in Waikato for Disability Support Link and speaks te reo.

The clinical and quality manager provides support to a number of Oceania facilities, is a registered nurse, and has a certificate in business management, diploma in management and 13 years’ experience in aged care including home care and hospital/rest home /dementia facilities. The clinical and quality manager has been in management roles for eight years and with Oceania for three years.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.3: 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 Moderate

**Evidence:**

Trevellyn Home and Hospital uses the Oceania quality and risk management framework that is documented to guide practice.

The business plan is documented and reported on through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Oceania head office reviews all policies with input from business and care managers. The policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. The policies are readily available to staff in hard copy at the nurses stations and in the business and care manager’s office. New and revised policies are presented to staff to read and staff sign to say that they have read and understood – sighted and confirmed by the five health care assistants interviewed.

The service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with a corrective action plan documented and evidence of resolution of issues.

All staff interviewed including five of five health care assistants, the activities coordinator, the diversional therapist, five of five registered nurses, the maintenance staff, the clinical manager, the two cooks and the business, care and village manager report they are kept informed of quality improvements.

There are annual family and resident satisfaction surveys which last took place in July 2013 with the relative satisfaction survey already beginning to be collated for July 2014. The overall level of satisfaction rate of residents and families is satisfactory to very satisfactory.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2013-14 with a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.

There are meetings held across the service including monthly quality staff meetings, monthly infection control, monthly resident, six monthly family, three monthly restraint and regular meetings for each group of staff e.g. registered nurse, health care assistants, housekeeping. All aspects of the quality and risk management programme are discussed through the meetings apart from incidents and accidents which are not evidenced as being discussed through the meetings particularly through the staff quality meetings. An improvement to discussion around incidents and accidents is required.

There is a monthly newsletter and a community connect newsletter from the organisation. This keeps residents up to date with changes in the service and wider organisation.

The service is able to show significant quality improvements that are aimed at improving the lives of residents. Key projects that are currently in progress or that have been completed include the following: i) upgrading of rooms as these become empty, ii) introduction of Inter RAI, iii) development of the courtyard that is interactive and is described by residents and family as being a focus of discussion and activity, iv) implementation of the ‘homely hotel’ project, v) the Connect model of care project that aims at linking ‘our people and our communities to created partnerships that develop and deliver excellence of care’, vi) the continuous quality improvement project looking at addressing any improvements required through certification and surveillance audits with a long term focus on achieving continuous improvement ratings, vii) upgrading of the nurse call system, viii) installation of a second nursing station for the hospital that allows activity and oversight/monitoring of residents in a hospital wing that was previously more isolated, ix) upgrading of specific areas with the intention of making them more resident focused e.g. conversation of a toilet that was not being used to a linen room so that linen trolleys are not left in hallways, five feature walls added, conversion of five four-bedded rooms to single rooms, upgrade of gardens at the entrance, carpet replaced throughout the facility, x) the addition of a registered nurse on night shift. The business, care and village manager, clinical manager, regional operations manager and the clinical and quality manager are committed to improving service delivery at Trevellyn Home and Hospital.

The residents, family, the chaplain and the general practitioner interviewed confirm a high level of satisfaction with the service with this reflected in the meeting minutes, through interviews and through the internal audit programme. There is also a robust layer of monitoring of service delivery from the management team and through the quality programme.

The District Health Board contract requirements are not fully met.

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

**Evidence:**

There are a range of meetings which allow all staff to be engaged in discussions around quality improvement and risk management. All aspects of the quality improvement programme is linked to the quality management system with policies and procedures documented apart from incidents and accidents.

**Finding:**

There is little evidence in the 2014 meeting minutes of discussion around incidents and accidents.

**Corrective Action:**

Ensure that there is a forum to discuss incidents and accident data with information leading to quality improvement.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The business, care and village manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical manager, business, care and village manager and clinical and quality manager.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Twenty-eight incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.

Information gathered is regularly shared at the monthly executive management and regional meetings with the business, care and village manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring (refer 1.2.3.5).

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All registered nurses and the clinical manager hold current annual practising certificates. Visiting practitioner’s practising certificates include the general practitioner, dietitian, podiatrist and physiotherapists.

Twelve staff files randomly selected for audit include appointment documentation on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid and CPR certificates are held in staff files. Police checks are completed.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract.

Health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower.

The organisation has a mandatory education and training programme with sessions held monthly. Staff attendances are documented and there is evidence of good staff attendance. The five health care assistants state that they value the training. Education and training hours exceed eight hours a year.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy (88 residents currently in the service).

There are three registered nurses on in the morning (two in the hospital and one in the rest home area) and two registered nurse in the afternoon and at night.

There are six health care assistants in the morning and afternoon and two overnight in the hospital and four health care assistants in the morning, four in the afternoon (two short shift) and two overnight in the rest home.

The business, care and village manager works full-time Monday – Friday and the clinical manager (registered nurse) also works full-time.

Residents and families interviewed confirm staffing is adequate to meet the residents’ needs.

There are currently 53 staff including the business, care and village manager, clinical manager, 14 registered nurses, diversional therapist, one activities coordinator, maintenance, five laundry, five housekeeping, contracted physiotherapists, 55 health care assistants.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### 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:**

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered, at admission, with the involvement of the family. There is sufficient detail in resident files to identify residents' on-going care history and activities. Resident files are in use that are appropriate to the service.

There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.

Entries are legible, dates and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.

Resident files are protected from unauthorised access by being locked away in an office. Informed consent is obtained from residents/family/whanau on admission to display photographs. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.

Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication and this is appropriate to the service.

The District Health Board contract requirements are met.

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

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

**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:**

The resident’s entry in to the service is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff who are competent to perform their role. Annual practising certificates are sighted for all staff that require them. All 10 of 10 residents’ files sampled confirm that registered nurses (RNs) conduct the initial assessment and develop the initial person centred care plan. The clinical manager (CM) is currently completing the InterRAI requirements towards obtaining competency and holds the current position since July 2013.

The 11 residents interviewed and 10 family members state that they had received the information pack and had received sufficient information prior to and on entry to the service. The information pack includes what the service provides, the code of rights, complaints process and advocacy services. The CM reports that needs assessments are required prior entry to the facility.

The admission agreement aligns with the District Health Board contract. The 10 of 10 resident files sampled have signed admission agreements.

The District Health Board contract requirements are met.

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

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

**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:**

The facility has an enquiry folder that keeps both walk in and telephone enquiries. There is a section in the enquiry form which records the reason for declining entry to the service. The CM reports that they decline resident’s entry to their service when the resident does not qualify for the level of care they provide. The CM also mentions that in the event that they cannot accept the resident due to a different level of care requirement, they refer the resident to another service either within the area or to another facility that can meet the resident’s level of need. The records of declined potential residents are sighted in the enquiry folder. Declined residents are also referred back to the referrer in a timely manner to discuss other referral options especially in the case of telephone enquiries.

A policy on declining entry to the service is sighted.

The District Health Board contract requirement is met.

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

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

**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 Moderate

**Evidence:**

The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals. There is a policy and process that describes resident’s admission and assessment procedures. The clinical manager (CM) or registered nurses (RNs) undertake the assessments on admission using standardised tools. The initial risk assessment tools and ongoing assessments include cognition, mobility, safe handling, pressure risk, gait, oral, dietary, continence, pain, cultural and recreation. An initial plan of care is developed on admission and sighted in 10 of 10 reviewed residents’ files to provide guidance to all staff in managing the new resident. The admission information, medical notes, allied notes, progress notes, staff inputs as well as resident/family inputs form the basis of the long-term care plan developed within three weeks of admission. The activities assessment is completed within three weeks of admission.

Medical assessments are completed within 24-48 hours of admission by the general practitioner (GP) in all 10 reviewed resident’s files. The GP examines the residents either monthly or three monthly depending on the resident’s level of needs and this is documented in the medical notes. The CM reports that hospital residents are examined monthly or more frequently as sighted in five out of five reviewed hospital resident files.

There is a verbal hand-over between shifts as witnessed during the day of the audit. The contents of the hand-over are not comprehensive to ensure continuity of care. An example is about a resident with infection receiving antibiotics but not mentioned during the hand-over. The afternoon RN interviewed after the hand over is not aware that the resident is already receiving antibiotics. An improvement is required to the handover process.

Short term care plans are sighted in all 10 of 10 reviewed residents’ files.

Progress notes are maintained and documented in each shift. All 10 of 10 reviewed resident’s files identify integration of allied professionals including GP, RNs, health care assistants (HCAs), physiotherapy and other specialists. Hospital discharge letters and specialist letters and referrals are sighted in the resident’s files including wound referral, disability support and mental health.

The 10 of 10 reviewed residents’ files evidence that the person centred care plans (PCCPs) are based on the assessed needs of the residents with the exemption of one rest home resident where the resident’s pain is not reflected in the PCCP. One respite resident’s initial plan of care or short term care plan do not reflect that the resident is in pain and on regular analgesia. One hospital resident’s falls risk assessment is not updated and interventions are insufficiently detailed. These are areas for improvement in 1.3.3.3.

The PCCPs are recorded on a standardised template that reflect the current needs and desired outcomes of the residents. The PCCP is individualised but do not consistently identify the need, assistance required, special instructions and goals. There is an ongoing six monthly evaluations sighted in 10 of 10 reviewed resident’s files. A multi-disciplinary review (MDR) process is conducted six monthly and the outcome of the review is communicated to the resident’s family via correspondence, email or telephone as sighted in the communication records in 10 of 10 reviewed resident’s files.

Tracer Methodology 1- Rest home level of care

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

Tracer Methodology 2 – Respite level of care

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

Tracer Methodology 3 – Hospital level of care

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

The District Health Board contract requirement is not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The signs and symptoms of infections are not clearly documented in the two out of two files reviewed.. Antibiotics are prescribed by the GP but there is no documentation sighted in the resident’s progress notes in the relation to the manifested signs and symptoms, assessments conducted by the registered nurses, vital signs obtained and other relevant information prior commencing the resident on antibiotics.

The 10 of 10 reviewed residents’ files evidence that the person centred care plans (PCCPs) are based on the assessed needs of the residents with the exemption of one rest home resident where the resident’s pain is not reflected in the PCCP. One respite resident’s initial plan of care or short term care plan do not reflect that the resident is in pain and on regular analgesia. One hospital resident’s falls risk assessment is not updated and interventions are insufficiently detailed.

**Finding:**

There is evidence documentation is not consistently provided within the time frames that safely meet the needs of the residents.

**Corrective Action:**

Staff to conduct assessments and document the outcome of the assessment in the resident’s clinical file.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (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:** PA Low

**Evidence:**

The service utilises a hand-over sheet as sighted in the afternoon hand-over of RNs and health care assistants (HCAs). All staff on duty participate in the witnessed hand-over. The contents of the hand-over are not comprehensive to ensure continuity of care for the residents. An example is a resident receiving antibiotics for infection but this not being communicated in the witnessed hand-over. The afternoon RN is not aware that the resident is already receiving treatment for infection. A urine sample is sent to the laboratory but the reason that prompted the RN to obtain a urine sample is not discussed during the witnessed hand-over.

**Finding:**

The contents of the hand-over are not comprehensive to ensure continuity of care for the residents.

**Corrective Action:**

Contents of the hand-over must be detailed to capture vital information including antibiotics, resident’s conditions during the shift and the rationale of undertaken procedures/sampling.

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

The clinical manager (CM) or the registered nurses (RNs) undertake a comprehensive initial assessment on admission using standardised tools. The initial risk assessment tools and ongoing assessments include cognition, mobility, safe handling, pressure ulcer risk, gait/balance, oral, dietary, continence, pain, cultural and recreation. Baseline vital signs and weights are taken on admission and recorded. The data collected during the assessment are utilised to develop the initial plan of care for the resident with the involvement of the resident and/or family. The resident’s preferences including food, linens and sleeping habits are clearly documented in all 10 reviewed resident’s files. The information gathered by the RNs serve as the basis for the person centred care plans of the residents.

The CM and RNs ensure that the new resident and their family if involved are orientated to the facility including meal times, how to reach staff, complaints process and other relevant information which they require to settle in their new home.

The GP admits the new resident within 24-48 hours and completes a medical assessment as sighted in all 10 reviewed files. The CM is currently undergoing interRAI assessment training and will work through files to put onto interRAI when signed off as competent.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The initial assessment forms the basis for the person centred care plans (PCCPs) developed within three weeks of admission as sighted in 10 out of 10 reviewed resident’s files. There is evidence that the PCCPs are developed with the resident and/or with their families. Resident needs, goals, objectives and interventions are identified, agreed and care to be delivered is explained with the resident when able as well as with the resident’s family. The 10 PCCPs sighted cover all areas to support the identified needs of the resident.

Short term care plans are developed when residents have infections as sighted in10 out of 10 reviewed resident’s files. The plans are specific and resident-focused. The CM and/or RNs update both PCCPs and short term care plans depending on the resident’s response to the planned interventions and treatment regimen.

The service delivery plans demonstrate integration system. The GP, RNs, health care assistants, physiotherapist, diversional therapist and other allied personnel write in the progress notes. The inputs from the members of the health team are sighted in 10 out of 10 reviewed resident’s files.

The District Health Board contract requirements are met.

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

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

**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:** PA Low

**Evidence:**

The service provides both rest home and hospital levels of care. They also provide care for younger people with disability (YPD). Individualised and resident-focused PCCPs are developed by the CM and RNs. When a resident’s condition changes, the CM and/or RNs initiate a review and if required, a consultation with the GP or with a specialist.

The four out of ten interventions in the PCCPs are not always well documented with insufficiently detailed strategies to address the desired outcome/goal of the resident. This is an area for improvement in 1.3.6.1.

The facility has sufficient equipment such as hoists, wheelchairs and handling belts to transfer or to assist residents to mobilise. There is an adequate supply of dressings, continence products and linen for residents for staff to use.

There are two physiotherapists and a physiotherapy assistant who are actively involved in maintaining and improving residents’ mobility. The mobility section of the PCCP reflects the inputs from the physiotherapists in 10 out of 10 reviewed resident’s files.

The pain assessments and evaluations are sighted for the five reviewed resident files on controlled drugs and regular analgesia. The effectiveness of pain relief is documented in the progress notes and handed-over when this requires monitoring and evaluation. There are vital signs, blood sugar levels, fluid balance and weight monitoring forms sighted. The CM and RNs can access the GP when medical issues arise or when there is a change in the resident’s current condition, suspected infections, medication requests/clarifications. The GP confirms that the RNs contact the surgery when required and implements orders with utmost efficiency. The CM refers the residents to other specialists like speech language, dietitian and mental health services when required.

The residents interviewed state that their needs are being met and that they are receiving appropriate clinical, medical and personal care. The family members interviewed confirm the residents’ statements and verbalise that they are very satisfied with the care the service provides for their relatives.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The CM or RNs develop the PCCP with interventions that meet the resident’s assessed needs, or desired interventions.

**Finding:**

The four out of ten reviewed resident’s files have interventions that are not well documented with insufficiently detailed strategies to address the desired outcome/goals of the residents.

**Corrective Action:**

Document interventions including strategies that will address the desired outcomes or goals.

**Timeframe (days):** 180 *(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 activities for the residents are planned by the diversional therapist (DT) with the use of a published diversional therapy book and previous activities that are appropriate for the residents. The programme includes activities that are physical, intellectual, spiritual, sensory, social and fun. There are group activities for crafts, paintings and drawings. An entertainer visits the facility every month. The service takes the residents for bus trips, outings, cafes, library visits and shopping by a designated driver. The van driver holds a current first aid certificate and first aid supplies are sighted in the van during the audit. There are bible sharing activities and hymns officiated by various religious sectors.

Activities involvement of the residents is monitored by a qualified diversional therapist using an attendance checklist. The DT is supported by an activities coordinator.

The timeline of weekly activities are available and posted in the activities boards and in the main entrance. The DT develops “Between us” - a monthly newsletter with the planned activities incorporated in order for the residents to plan which activity they will participate. The hospital level of care residents have a separate activities plan from the rest home level of care residents.

The DT forms the activities plan using the recreation assessment during admission. There is a section in the PCCP for the activities plan for 10 out of 10 reviewed residents’ files.

During the audit, the residents are noted to be enjoying the entertainment provided during the day. The residents interviewed verbalise that the activities provided for them by the activities coordinator and diversional therapist is enjoyable, stimulating and tailored to their needs as well as for the group. Residents participate in their preferred activities and this is documented in 10 out of 10 reviewed activities plans in the PCCP.

The District Health Board contract requirements are met.

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

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

**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:**

The 10 out of 10 person centred care plans are evaluated six monthly and updated when clinically indicated as sighted in the documentation. Short term care plans are evaluated and resolution of the problems are documented in the short term care plans. The degree of achievement or response to the intervention is clearly documented in the short term care plans and in the resident’s progress notes. The treatment regimens are changed or modified when the resident’s response to treatment is different from expected as sighted in short term care plans. There is a documented monthly and three monthly GP review depending on the complexity of the resident. There is a multi-disciplinary review (MDR) approach to the review of the PCCP that occurs annually. The resident and family when available are invited to attend the MDR meeting for discussion. Families who are not able to attend are provided with a copy of the MDR outcome.

The resident’s involvement in the planned activities are evaluated six monthly as sighted in the documentation. The DT reports that the evaluations are opportunities to explore other possible activities which are interesting and stimulating for the residents. The RNs are informed when the resident is not participating in activities in order to further evaluate the resident’s mobility, cognition, pain, depression, and other interests.

The District Health Board contract requirements are met.

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

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

**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 CM and RNs facilitate residents’ access to other medical and non-medical services available for them. The CM confirms initiating referrals for continence, wounds, disability support for change in level of care, mental health/psychiatric services, podiatry, physiotherapy, speech language therapy and dietitian. The GP initiates specialist referrals as sighted in the medical notes. A referral form is utilised by the CM and previous referrals are evidence in the documentation.

Rest home residents when they deteriorate are referred by the CM to disability support to change the level of care. The families are informed by the CM when reassessments are completed as well as the outcomes.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

There is a policy that describes guidelines for transition, exit, discharge or transfer from services. The clinical manager (CM) reports that they just started utilising the yellow envelope to transfer residents to the public hospital and to receive residents back from the public hospital. The CM mentions that the resident’s PCCP is attached with the medication charts when a resident is transferred to another facility or when taken to the hospital for acute admissions. A copy of the resuscitation status is included in the discharge notes including the last GP notes, a copy of the relevant progress notes and other relevant documentations. Hospital discharge notes and plans are received on discharge from the hospital.

The CM and the RNs confirm that risks are identified prior to a transfer or discharge of a resident. There is an open communication between the service, the GP, the resident and families if available.

The District Health Board contract requirement is met.

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

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

**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:**

A medicines management system is implemented to manage the safe and appropriate dispensing, storage, disposal, and medicine reconciliation in order to comply with legislation, protocol, and guidelines. Refer to 1.3.12.6 for the finding regarding review of medication charts.

Medicines for residents are received from the pharmacy in a packed medicine delivery system. The medicines are checked for accuracy against the resident’s medication charts. A medicine reconciliation process occurs with new admissions and when the resident returns from a specialist or hospital admission. Medicines are stored in locked medicine cupboard and staff administering medications keeps the packs inside a locked medication trolley as sighted during the lunch time medication rounds. The two staff administering the lunch time medications are following the medication procedure.

A weekly stocktake is conducted by two staff for the controlled drugs. There are six unsigned or not countersigned areas in the controlled drugs register (refer to 1.3.12.6). The residents receiving controlled drugs have appropriate pain assessments in their files. The fridge is monitored daily by the night staff as sighted in the fridge temperature monitoring sheet. There are sharps bin containers sighted in the medication room. There are four out of 21 medication charts not reviewed three monthly by the GP. Refer to 1.3.12.6. This is recorded on the medication charts. All prescriptions sighted contain the date, medicine name, dose and time of administration. There are two out of 21 medication charts without allergies written. Refer to 1.3.12.6. There is a photo of each medicine is shown in the medication chart to guide staff administering the medicines. A current photo of the resident is sighted in all 21 sampled medication charts. The medications that require to be crushed are not recorded to a level of detail to ensure resident/patient safety. Refer to 1.3.1.2.6.

There is a crushing policy in place that provides a clear guideline for the staff. Expired or unwanted medicines are kept in a returns basket and are sent back to the pharmacy via the pharmacy delivery staff. There are no expired medicines sighted during the medication room inspection.

The clinical manager reports that there is no resident self-administering medicines. The medicine self-administration policy is sighted and the CM/RNs are able to demonstrate knowledge in procedure when a resident self-administers own medications.

The medication competencies for all the 16 RNs and 13 health care assistants are current and evidence in the documentation.

The District Health Board contract requirements are not fully met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A medicines management system is implemented to manage the safe and appropriate dispensing, storage, disposal, and medicine reconciliation in order to comply with legislation, protocol, and guidelines. Refer to 1.3.12.6 for the finding regarding review of medication charts.

Medicines for residents are received from the pharmacy in a packed medicine delivery system. The medicines are checked for accuracy against the resident’s medication charts. A medicine reconciliation process occurs with new admissions and when the resident returns from a specialist or hospital admission. Medicines are stored in locked medicine cupboard and staff administering medications keeps the packs inside a locked medication trolley as sighted during the lunch time medication rounds. The two staff administering the lunch time medications are following the medication procedure.

A weekly stocktake is conducted by two staff for the controlled drugs. There are six unsigned or not countersigned areas in the controlled drugs register (refer to 1.3.12.6). The residents receiving controlled drugs have appropriate pain assessments in their files. The fridge is monitored daily by the night staff as sighted in the fridge temperature monitoring sheet. There are sharps bin containers sighted in the medication room. There are four out of 21 medication charts not reviewed three monthly by the GP. Refer to 1.3.12.6. This is recorded on the medication charts. All prescriptions sighted contain the date, medicine name, dose and time of administration. There are two out of 21 medication charts without allergies written. Refer to 1.3.12.6. There is a photo of each medicine is shown in the medication chart to guide staff administering the medicines. A current photo of the resident is sighted in all 21 sampled medication charts. The medications that require to be crushed are not recorded to a level of detail to ensure resident/patient safety. Refer to 1.3.1.2.6.

**Finding:**

There are 21 medications charts reviewed with the following issues:

1. Nine out of 21 reflect transcribing of medications by staff administering medications.

2. Four out of 21 are not reviewed by the GP every three months.

3. Four out of 21 discontinued medications are not signed by the GP.

4. Two out of 21 have no allergy written.

5. There are six areas either not signed or not countersigned in the controlled drugs register. There is no incident report completed by the staff for the six medication errors sighted.

6. There are 9 unsigned areas in the signing sheets. There is no incident report completed by staff for the 9 unsigned medication areas identified.

7. The medications that require to be crushed are not recorded to a level of detail to ensure resident/patient safety.

**Corrective Action:**

1. Staff must not transcribe medications; follow procedures in medicine administration including documentation and controlled drugs policies and procedures.

2. GP to review all medication charts every three months, sign all discontinued medications and write allergies in all medication charts.

3. Staff to complete incident reports for medication administration/procedural errors.

4. Medications to be crushed must be recorded in detail in the medication charts.

**Timeframe (days):** 30 *(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 Food Service Manual is sighted. The clinical manager (CM) or registered nurses on duty (RNs) admit new residents to the facility and complete a dietary requirement form, a copy is given to the kitchen manager. The resident’s food dislikes are written in the comments section including food allergies. There is a diet code sighted in the kitchen board.

The kitchen manager holds a current food handling certificate as sighted in the kitchen manager’s employment file including the seven staff working in the kitchen. The service provides modified diet like gluten-free, moulie, diabetic and minced/moist.

The four week rotating menu is reviewed by the dietitian, last review was conducted in March 2014 for winter menu while the summer menu is reviewed last September 2013. The served meals are suitable for older people and the food presented during the audit is still as the current menu. Food temperatures are conducted daily as sighted in the food temperature monitoring as well as the fridge/freezer/chiller temperature monitoring. The fridges are clean and with intact rubber seals. The kitchen manager reports that the cooked meat’s temperatures are recorded immediately after is removed from the oven and before being placed in the bain marie before the food is served. Special food and dietary requirements can be arranged by the cook and the meals are well presented.

Staff are using clean technique in food preparation. They are wearing hair net, kitchen gloves and aprons. The staff serving the meals remain wearing hair nets as sighted.

The kitchen manager rotates canned goods and labels all cooked and opened foods in the chiller and fridge. The kitchen is clean and there are adequate food supplies in the pantry. The kitchen manager places order directly to the supplier and checks quantity and quality of delivered items. A cleaning schedule is conducted daily as sighted in the cleaning schedule signing sheet.

Weight monitoring is sighted in 10 out of 10 reviewed resident’s file.

The District Health Board contract requirements are met.

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

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

**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:**

Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.

Material safety data sheets are available throughout the facility and accessible for staff.

The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances – last provided in February 2014 with Ecolab.

The provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. During a tour of the facility protective clothing and equipment was observed in all high risk areas. Three housekeeping staff confirm that they have received training in the last year and attendance records are sighted.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening. Infection control policies state specific tasks and duties for which protective equipment is to be worn.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 1 December 2014). There have been no building modifications since the last audit although rooms have been refurbished and five four-bedded rooms have been converted into single rooms.

There is a planned maintenance schedule implemented with the maintenance staff able to describe the process.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats, chair scales and a weight machine to monitor the weight of anyone in a wheelchair. There is a test and tag programme two yearly and this is up to date.

Interviews with five of five caregivers, five registered nurses and the clinical manager confirm there is adequate equipment including equipment for residents identified as requiring hospital level care.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that are easy to access for residents and family members.

The District Health Board contract requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

There are adequate numbers of accessible toilets/bathing facilities. This includes visitor’s toilets and communal toilets conveniently located close to communal areas.   
Communal toilet facilities have a system that indicates if it is engaged or vacant with some having locking systems.

Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

Eleven residents (six rest home and five hospital) and ten family members (six hospital and four rest home) interviewed report that there are sufficient toilets and showers with a number of rooms having their own ensuite.

##### **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:**

There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.

Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff and the resident. Residents requiring use of a hoist were sighted on the day with staff supporting them in their rooms with sufficient space for all.

Rooms can be personalized with furnishings, photos and other personal adornments.

There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required and an area for wheelchairs.

##### **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 lounge/dining areas and all areas have appropriate floor coverings. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.

Residents and family interviewed state that there are sufficient spaces for them to meet, relax and engage in activities.

The District Health Board requirements are met.

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

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

**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:**

Laundry is completed in a large area downstairs with the service also completing the laundry for another provider. The three laundry assistants and the housekeeper describe sound systems to keep the laundry from the two services separated with all laundry covered during transport. There is a ‘dumb waiter’ to get linen at Trevellyn Home and Hospital from the upstairs rest home and hospital areas to the laundry.

Eleven residents (six rest home and five hospital) and ten family members (six hospital and four rest home) interviewed state that the laundry is well managed and they get back their clothes in a timely manner.

There are cleaners on site during the day seven days a week. The cleaners were observed to have the trolley in the room with them when cleaning and all had appropriately labelled containers.

Cleaning is monitored through the internal audit process with no issues identified in audits last completed in March 2014.

Chemicals and cleaning cupboards are locked and there is a locked door at the top of the stairs to stop any unauthorised people going into the laundry area. Cleaning audits are completed as per schedule with the last completed in April 2014.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An evacuation plan is approved by the New Zealand Fire Service. There have been no building reconfigurations since the date of the approval of the evacuation plan. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly. The orientation programme includes fire and security training. Staff confirm their awareness of emergency procedures. Checks of fire equipment and safety procedures occurs monthly e.g. of backflow prevention, fire doors, emergency warning systems and lighting, signs etc.

There is always one staff member at least with a first aid certificate on duty – confirmed through review of the roster and confirmed by the business, care and village manager.  
All required fire equipment is sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ with yellow plugs available in which to plug a generator. A back up battery for emergency lighting is in place with the maintenance staff describing regular checks of this.

An electronic call bell system is in place and this has been updated over the last year. There are call bells in all residents’ rooms, residents’ toilets, and communal areas including the hallways and dining room.

The doors are locked in the evenings doors can only be opened from the inside. Systems are in place to ensure the facility is secure and safe for the residents and staff.

External lighting is adequate for safety and security with sensor lights on the outside of the building.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.8: Natural Light, Ventilation, And Heating **(**HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.

Family and residents interviewed confirm the facilities are maintained at an appropriate temperature.

The District Health Board contract requirements are met.

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

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

**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 minimisation policy and procedures sighted and implemented. The restraint register is current with 11 residents using restraints and one resident using an enabler. Restraint assessments are completed and restraint consents are signed by the restraint coordinator, GP and family/resident. Risk management plans are sighted in all 11 resident’s long-term care plans (restraint section) and three monthly evaluations are evidenced. Restraint minimisation and safe practice is encouraged.

The clinical manager (CM) is the restraint coordinator and the restraint coordinator job description is sighted in the restraint folder. The restraint coordinator also conducts yearly restraint minimisation audit and the outcome for this year’s restraint audit is all fully achieved. The restraint in-service training is last conducted by the restraint coordinator in March and April 2014. The contents of the in-service as sighted and includes definition of restraint, difference of restraint and enabler and other relevant information relevant to restraint.

The resident on enabler when interviewed state they requested for the enabler (bedrail) to be in place and use the enabler to maintain independence.

##### **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:**

The restraint minimisation policy and procedure is sighted and implemented by the service. Residents when on restraint are monitored using the restraint monitoring form. Staff complete the monitoring form as sighted in the three reviewed resident’s files on restraints. The five interviewed health care assistants (HCAs) are able to demonstrate knowledge about the restraint approval process, the risk management for residents on bedrails and the difference between a restraint and an enabler.

Restraint in-service education is last completed in March and April 2014. All staff have current restraint competencies as sighted in the staff restraint competency register.

The District Health Board requirement is met.

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

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

**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:**

The restraint coordinator ensures that rigorous assessment of the resident is undertaken in relation to the use of restraint. The restraint coordinator completes a restraint assessment prior commencing the use of any restraint for any resident. Risk management plans are developed as sighted in three out of three reviewed resident’s files on restraint. All of the residents on restraint have on-going evaluations as sighted in the documentations. Alternative interventions are documented in the restraint assessment forms sighted.

The restraint coordinator verbalises that the residents and their families are involved in the discussion regarding the restraint process. The purpose and reason of the restraint including risk management plans are presented to the families prior commencing the restraint.

The District Health Board contract requirement is met.

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

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

**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 uses restraint safely. The bedrails are with padded covers when in use and are checked regularly as per annual equipment’s maintenance plan. The service reports that use low beds, crash mattresses and sensor mats before resulting to use of bed rails. The decision to approve restraint for a resident is made following appropriate planning and preparation by the restraint coordinator and the restraint committee. The restraint committee meets every three months and the minutes of the meetings are sighted in the evidence.

The type of restraint, duration of use, frequency of monitoring and desired outcome are clearly stated in the restraint assessment and evaluation forms. The risk management plans are documented in three out of three reviewed resident’s person centred care plans. The monitoring forms are completed by all staff after each shift. The five staff interviewed are able to discuss why monitoring is important and the resident’s needs to be checked including hydration, comfort, continence, pain, position and nutrition.

A restraint register is current and is established to record sufficient information to provide an auditable record of restraint use including evaluation dates and the date when the restraint is not required.

The District Health Board contract requirement is met.

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

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

**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 coordinator evaluates all restraints in use for the residents. The restraint evaluations are conducted three monthly as sighted in all 11 residents using bedrails as restraint and one resident on enabler. All restraint evaluations for the 11 residents using bedrails and one resident on enabler are sighted in the resident’s files. The restraint risk management plans are updated when required as reported by the restraint coordinator. There are no restraint-related injuries reported by the restraint coordinator or by the five interviewed staff.

The District Health Board contract requirement is met.

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

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

**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:**

The service demonstrates monitoring and quality review of the use of restraint. The restraint minimisation policy and procedures are last reviewed in March 2013. Trends are established and included in the review process. The risk management plans are evidence in the five reviewed resident’s files who are on restraint. The three monthly restraint evaluations are sighted in all 11 reviewed resident’s files using bedrails. The restraint coordinator provides restraint in-service trainings for all staff and is last conducted in March and April 2014.

The District Health Board contract requirement is met

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

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

**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:**

There are clear lines of accountability for infection control and prevention for the service. Infection control and prevention is integrated into the monthly quality meetings. The infection control programme is appropriate to the size and scope of the service. One of the RN is the designated infection control nurse (ICN) and is new to the role. The clinical manager provides guidance to the ICN. The job description of the infection control nurse is signed as evidence in the staff file.

The five interviewed health care assistants (HCAs) are able to demonstrate good knowledge on preventing the spread of infection, breaking the chain of infection and had confirmed some of the infection control programme of the service. The five health care assistants also verbalise that they will take a sick leave when not able to attend their shift and when to inform management regarding signs/symptoms of an outbreak of infectious disease. The five interviewed health care assistants verbalise that they have better understanding about infectious diseases after the service had an outbreak on February 2014. The cleaner shows good knowledge of infection control prevention.

Visitors, families and staff are reminded not to enter the service when not feeling well. There is a sign noted in the reception area of the service. A hand sanitizer is also sighted throughout the facility.

The infection control programme is last reviewed in February 2014 as sighted in the evidence.

The District Health Board contract requirement is met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### 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 clinical and quality manager as well as the clinical manager provide guidance to the newly-appointed ICN. The infection control committee includes qualified health professionals with the relevant skills, expertise and resources necessary to achieve the infection control standards. There is a representative from the different areas within the service (care staff, nursing, maintenance, laundry, and kitchen). The last infection control committee meeting was conducted in July 2014 is evidenced in the records.

There are infection control signage within the service to inform staff, residents and visitors on how prevent the spread of infections. Hand gels are available and sufficiently distributed inside the facility.

The infection control nurse has access to relevant and current information’s including internet, intranet, the Ministry of Health web pages, access to DHB experts and laboratory services. There is also an ongoing in-service education on infection control and prevention as sighted in the education programme of the service. The last in-service was conducted in June 2014 is sighted in the records.

The infection control programme is last reviewed in February 2014.

The District Health Board contract requirement is met.

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

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

**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:**

The service has documented policies and procedures, implemented for the prevention and control of infection, that reflect good practice that meet relevant legislative requirements. These policies and procedures are practical, safe, and appropriate for the type of service provided.

The four interviewed health care assistants (HCAs) confirm that the policies and procedures are accessible to them when they need to read about certain topics. Infection control prevention and control is integrated in the orientation programme for all staff as sighted in four staff files. The contents of the orientation for infection control prevention and control are comprehensive and practical. The staff added that the use of gloves needs to be single use and must not be worn in the corridors. The health care assistants also mention that the infection control nurse and clinical manager are available to them to clarify infection control issues or some procedural concerns regarding infection control.

The District Health Board requirements are met.

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

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

**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:**

The service provides relevant education on infection control prevention and control to all staff and residents. This is evident in the monthly staff and residents’ meetings.

The four interviewed health care assistants (HCAs) confirm that there are in-service trainings on hand-washing, use of personal protective equipment’s (PPE), antimicrobials, spread of infections and signs/symptoms of an infectious disease. The in-service in outbreak management, antimicrobials, standard precautions and surveillance is held last in June 2014. A record of this in-service is evidence in the education planner. The five interviewed health care assistants are also able to demonstrate good knowledge on infection control and prevention.

The 11 residents verbalise that staff talk about the importance of hand washing to them especially before eating and after using the toilet. They residents added that they are more aware of breaking the chain of infection after the incidence of an outbreak in the facility last February 2014.

The District Health Board contract requirement is met.

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

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

**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:**

The surveillance for infection rate is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control surveillance is appropriate to the size of the service. Infection rates are monthly monitored and collated by the infection control nurse with the guidance of the clinical manager including urinary tract infections, skin, wound, respiratory tract infections, gastro-intestinal tract infections and ears/ear infections. These infections are entered in the intranet system for benchmarking with other services within the organisation. Infection rates are discussed during the monthly quality meeting as sighted in the quality meeting folder. The interventions to reduce, manage and prevent the infections are discussed during monthly quality meetings as evidence in the records.

The results of the monthly infection surveillance are sighted in the intranet and monthly quality meetings.

##### **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.)*