Stanthom Properties Limited

Current Status: 9 September 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

San Michele Home and Hospital is a stand-alone facility owned and operated by Stanthom Properties Limited. The day to day operation of the facility is overseen by the business manager who is supported by the nurse manager who oversees all clinical aspects of care. On the day of audit there are seven rest home and 19 hospital level care beds occupied.

Residents and family/whānau members confirm during interview they are happy with care and services provided. None of the 12 GPs who have residents in the facility were available to talk on the days of audit.

This audit identified 10 areas that require improvement. These relate to complaints management, quality and risk systems, human resources management, medicine management, the environment and restraint monitoring.

Audit Summary as at 9 September 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 9 September 2014

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

Organisational Management as at 9 September 2014

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

Continuum of Service Delivery as at 9 September 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 low risk.

Safe and Appropriate Environment as at 9 September 2014

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

Restraint Minimisation and Safe Practice as at 9 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Infection Prevention and Control as at 9 September 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 9 September 2014

Consumer Rights

The service has processes in place that demonstrates their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whānau are informed of their rights as part of the admission process, with information on the Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services being included in the information given to residents when admitted. The Code is clearly displayed around the facility and information is accessible at the entrance to the facility.

Resident and family/whānau interviews confirm their satisfaction with the staff and provision of services. Services provided to residents are reflective of individual resident's and family/whānau wishes. The service implements policies, procedures and process to ensure residents are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural, values and beliefs are provided at the service.

Residents receive services of an appropriate standard for hospital and rest home level of care. The service provides a clinical environment that encourages good practice.

Staff communicate effectively with residents and family/whānau members' right to full and frank information and open disclosure is demonstrated. The service gains appropriate written consent for delivery of services. The residents are able to maintain links with their family/whānau and the community and have access to visitors of their choice.

The provider has implemented a process to address complaints, inclusive of follow up and close out of complaints. The provider received their last complaint in 2013. The provider has followed up with corrective actions and continues to monitor the effectiveness of the strategies implemented. An area requiring improvement has been identified related to the development of a complaints register.

Organisational Management

The mission statement and philosophy of the organisation are displayed in the main foyer and reflected in the quality improvement action plan. Objectives have been set for 2014 and evidence demonstrates the provider is working towards meeting targets set.

The business manager has worked for the organisation for approximately 18 years and attends regional management forums. Accountability for management of the facility sits with the business manager who is supported by the owners for substantial financial decisions. The nurse manager manages any clinical matters that arise. Management interviews identified there is a clear division of responsibilities and each respective manager displayed detailed knowledge of their own accountabilities.

Policies and procedures are reviewed two yearly or sooner if there is a change to practice. The internal audit programme is tracking to schedule but does not include the development of corrective action plans; this is an area identified for improvement.

Human resources are managed well with clear documentation related to recruitment, orientation and maintenance of performance appraisal systems. The provider has a policy identifying staffing rationale; rosters confirm appropriate coverage related to staffing ratios. Areas for improvement have been identified related to documentation of in-service training, maintenance of practising certificates, the need to update staff knowledge in relation to emergency management other than fire and maintenance of first aid certificates.

Incidents and accidents are documented and followed up by the nurse manager; outcomes are discussed at staff meetings.

Resident information is securely stored, accurate and up to date.

Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and deliver services to meet residents' needs. Entry criteria are clearly documented and referral agencies are aware of the level of care offered.

Staff are educated and experienced in aged care so they can perform their roles and deliver all aspects of service delivery to meet residents' needs. The nurse manager and registered nurses (RNs) oversee the care and management of all residents along with a team of caregivers.

The residents' care plans are well documented and clearly identify the resident's needs, which are reviewed six monthly, or more often as required. The resident and family/whānau are involved in care planning and review processes as appropriate. Clinical documentation is reviewed within required timeframes.

The activities are planned and delivered by a diversional therapist and are appropriate for residents requiring rest home and hospital level care.

Medication management systems are identified in policies and procedures to guide staff actions. Staff who undertake medication administration undertake annual competencies to ensure their knowledge and safety are maintained. Not all aspects of medicine management information are recorded to a level of detail to comply with legislation and guidelines. This is an area requiring improvement.

Food is prepared on site to meet menu plans which have been approved as appropriate for aged care residents by a registered dietitian. Each resident is assessed by a registered nurse on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food

requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

Safe and Appropriate Environment

The facility was built in the 1930s and the décor is showing signs of ageing. The provider has a plan to redecorate as part of the ongoing maintenance programme. Detailed records of a maintenance monitoring programme are held demonstrating monitoring requirements are being maintained. Appropriate space, ventilation, lighting and heating are available. Residents are able to personalise their rooms with picture and ornaments.

Emergency management supplies are well catered for in all areas except for water storage and the undertaking of a current fire evacuation drill. These are areas requiring improvement.

There are enough showering and toileting facilities to meet the needs of residents. One shower room shows signs of wear with chips in the wallboard, this is an area for improvement.

Laundry is completed on site and whilst the room only has one entrance, delineation has been made between clean and dirty areas. There are secure areas for locking chemicals away; however, there are improvements required related to a number of unsecured chemicals throughout the facility and unsecured oxygen bottles.

Restraint Minimisation and Safe Practice

The provider has implemented a comprehensive assessment, approval and monitoring process for restraints. Approval is discussed by the Restraints Approval Group and signed off by the GP and the nurse manager. Ongoing reviews are well documented and able to be evidenced in files reviewed. Documentation of monitoring of restraints shows some inconsistencies in eight of eight files reviewed related to accuracy and this is an area requiring improvement. The documentation inaccuracies were limited to afternoon shifts and all other shifts demonstrated a good level of documentation.

There were no enablers in use and all documentation sighted confirmed that only restraints were being utilised. Restraints in use are bed rails and lap belts. Staff were able to identify the difference between restraints and enablers.

A stable and long serving workforce has seen them complete there ACE training, Challenging Behaviour and Restraint Minimisation with successive refreshers. An area for improvement related to recording in detail information covered in training sessions has been identified as an area for improvement in 1.2 Organisational Management.

Infection Prevention and Control

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed annually. There are adequate resources to implement the infection control programme and the infection control coordinator is responsible for ensuring the programme is implemented at the facility. The service’s policies and procedures are developed by an external specialist organisation and personalised for the service. They comply with relevant legislation and current accepted good practice. The service

provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau.

Surveillance for infections is carried out on an ongoing basis. The surveillance data is collected, collated and analysed monthly against previously collected data. Interviews confirm that if an upward trend is identified the service implements actions to reduce the prevalence of infections.

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:	Stanthom Properties Limited
Certificate name:	Stanthom Properties Limited

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit
Premises audited:	San Michele Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 9 September 2014 **End date:** 10 September 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:	26

Audit Team

Lead Auditor	XXXXX	**Hours on site**	16	**Hours off site**	12

Other Auditors	XXXXXX	**Total hours on site**	16	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	4

Sample Totals

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

Number of residents interviewed	6	Number of staff interviewed	12	Number of managers interviewed	2
Number of residents' records reviewed	8	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	35	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	

Declaration

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

I confirm that:

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

Dated Monday, 6 October 2014

Executive Summary of Audit

General Overview

San Michele Home and Hospital is a stand-alone facility owned and operated by Stanthom Properties Limited. The overall day to day operation of the facility is overseen by the business manager who is supported by the nurse manager who oversees all clinical aspects of care. On the day of audit there are seven rest home and 19 hospital level care beds occupied.

Residents and family/whānau members confirm during interview that they are happy with care and services provided. None of the 12 GPs who have residents in the facility were available to talk on the days of audit.

There were no areas identified for improvement in the previous audit. This audit identified 10 new areas that require improvement. These relate to complaints management, quality and risk systems, human resources management, medicine management, the environment and restraint monitoring.

Outcome 1.1: Consumer Rights

The service has processes in place that demonstrates their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' right is embedded into everyday practice as observed during the audit. Residents and family/whānau are informed of their rights as part of the admission process, with information on the Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services being included in the information given to residents when admitted. The Code is clearly displayed around the facility and information is accessible at the entrance to the facility.

Resident and family/whānau interviews confirm their satisfaction with the staff and provision of services. Services provided to residents are reflective of individual resident's and family/whānau wishes. The service implements policies, procedures and process to ensure residents are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual's cultural, values and beliefs are provided at the service.

Residents receive services of an appropriate standard for hospital and rest home level of care. The service provides a clinical environment that encourages good practice.

Staff communicate effectively with residents and family/whānau members' right to full and frank information and open disclosure is demonstrated. The service gains appropriate written consent for delivery of services. The residents are able to maintain links with their family/whānau and the community and have access to visitors of their choice.

The provider has implemented a process to address complaints, inclusive of follow up and close out of complaints. The provider received their last complaint in 2013 which raised concern about flies. The provider has followed up with corrective actions and continues to monitor the effectiveness of the strategies implemented. An area requiring improvement has been identified related to the development of a complaints register.

Outcome 1.2: Organisational Management

The mission statement and philosophy of the organisation are displayed in the main foyer and reflected in the quality improvement action plan. Objectives have been set for 2014 and evidence demonstrates the provider is working towards meeting targets set.

The business manager has worked for the organisation for approximately 18 years and attends regional management forums. Accountability for management of the facility sits with the business manager who is supported by the owners for substantial financial decisions. The nurse manager manages any clinical matters that arise. Management interviews identified there is a clear division of responsibilities and each respective manager displayed detailed knowledge of their own accountabilities.

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Incidents and accidents are documented and followed up by the nurse manager; outcomes are discussed at staff meetings.

Resident information is securely stored, accurate and up to date.

Outcome 1.3: Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and deliver services to meet residents' needs. Entry criteria are clearly documented and referral agencies are aware of the level of care offered.

Staff are educated and experienced in aged care so they can perform their roles and deliver all aspects of service delivery to meet residents' needs. The nurse manager and registered nurses (RNs) oversee the care and management of all residents along with a team of caregivers.

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evidences compliance with current legislation and guidelines. Meals are provided at appropriate times of the day. Residents interviewed report satisfaction with the food service provided.

Outcome 1.4: Safe and Appropriate Environment

The facility was built in the 1930s and the décor is showing signs of ageing. The provider has a plan to redecorate as part of the ongoing maintenance programme. Detailed records of a maintenance monitoring programme are held demonstrating monitoring requirements are being maintained. Appropriate space, ventilation, lighting and heating are available. Residents are able to personalise their rooms with picture and ornaments.

Emergency management supplies are well catered for in all areas except for water storage and the undertaking of a current fire evacuation drill. These are areas requiring improvement.

There are enough showering and toileting facilities to meet the needs of residents. One shower room shows signs of wear with chips in the wallboard, this is an area for improvement.

Laundry is completed on site and whilst the room only has one entrance, delineation has been made between clean and dirty areas. There are secure areas for locking chemicals away; however, there are improvements required related to a number of unsecured chemicals throughout the facility and unsecured oxygen bottles.

Outcome 2: Restraint Minimisation and Safe Practice

The provider has implemented a comprehensive assessment, approval and monitoring process for restraints. Approval is discussed by the Restraints Approval Group and signed off by the GP and the nurse manager. Ongoing reviews are well documented and able to be evidenced in files reviewed. Documentation of monitoring of restraints shows some inconsistencies in eight of eight files reviewed related to accuracy and this is an area requiring improvement. The documentation inaccuracies were limited to afternoon shifts and all other shifts demonstrated a good level of documentation.

There were no enablers in use and all documentation sighted confirmed that only restraints were being utilised. Restraints in use are bed rails and lap belts. Staff were able to identify the difference between restraints and enablers.

A stable and long serving workforce has seen them complete there ACE training, Challenging Behaviour and Restraint Minimisation with successive refreshers. An area for improvement related to recording in detail information covered in training sessions has been identified as an area for improvement in 1.2 Organisational Management.

Outcome 3: Infection Prevention and Control

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed annually. There are adequate resources to implement the infection control programme and the infection control coordinator is responsible for ensuring the

programme is implemented at the facility. The service's policies and procedures are developed by an external specialist organisation and personalised for the service. They comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, including support staff, and when relevant, residents and family/whānau.

Surveillance for infections is carried out on an ongoing basis. The surveillance data is collected, collated and analysed monthly against previously collected data. Interviews confirm that if an upward trend is identified the service implements actions to reduce the prevalence of infections.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	42	0	8	0	0	0
Criteria	0	91	0	10	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	There is no complaints register that identifies all complaints, dates and actions taken.	To develop and implement a register that includes all complaints, dates and actions taken.	180
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	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		principles.				
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	There is no formal documented corrective action plans developed for issues arising from audit, complaints, incidents and accidents.	Develop and implement a system to document corrective actions that address areas for improvement in order to meet standards or requirements.	180
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.2	Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	There is no evidence of practising certificates for GPs, podiatrists or pharmacists.	Implement a process for validating the professional qualifications for all service providers.	180
HDS(C)S.2008	Criterion 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.	PA Low	The group attendance register for in-service education does not include enough detail to identify the detail of the topic covered. In May 2012, 11 staff completed CPR and ten staff completed Basic Life Support with an external consulting agency. 2. Renewal of staff first aid certificates has not been completed. 3. Recent training related to emergency/security situations cannot be evidenced; however the provider does have comprehensive policies related to the topic which staff have read at orientation. Interviews with five of five staff identified that they were not well versed in emergency and security situations, not related to fire.	1.Record the detail of what is covered in each in-service education session. 2.Complete staff renewals of first aid certificates. 3. Update staff education related to emergency/security situations.	180
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe and timely manner that	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	complies with current legislative requirements and safe practice guidelines.				
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 Low	Two of the 12 resident charts reviewed do not have GP three monthly reviews signed for. Nursing staff who administer medicines do not use the signing block on the medicine charts to identify their signatures. Standing orders do not state who may administer them and the maximum dose is not always identified.	Ensure medicine management information is recorded to a level of detail to comply with legislation and guidelines.	180
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	Unrestrained oxygen bottles pose a risk to residents and staff. (2) The wall board in one shower is chipped at the bottom and poses an infection control risk. (3) Metal framing and equipment in one bathroom is rusted.	Ensure all oxygen bottles are securely restrained at all times. Ensure equipment and environment surfaces are able to be easily cleaned.	180
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	Unsecured chemicals are identified within the facility.	All chemicals must be stored safely in a secured area.	180
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	The fire drill due in June 2014 has not been completed.	The overdue Fire Evacuation Drill is to be completed.	180
HDS(C)S.2008	Criterion 1.4.7.4	Alternative energy and utility sources are available in the event of the main supplies failing.	PA Low	There is insufficient water stored to meet the required 3 litres of water per person per day for three days.	Ensure there are adequate water supplies to meet the recommended amount of 3 litres of water per person per day for 3 days.	180
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 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;	PA Low	Documentation does not accurately reflect the time or action that had taken place.	Ensure all documentation accurately reflects the monitoring of the restraint.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		(g) Comments resulting from the evaluation of the restraint.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Service providers demonstrate and verbalise knowledge and understanding of residents' rights and obligations and incorporate them into everyday practice. They ensure residents who are in shared rooms have privacy when cares are being delivered by pulling curtains and when discussing matters of a sensitive nature with residents. Staff ensure conversations cannot be overheard.

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:

Opportunities are provided for explanations, discussion and clarification about the Code of Health and Disability Services Consumers' Rights (the Code) with the resident, family/whānau as part of the admission process and during multidisciplinary (MDT) review meetings. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service is clearly displayed at the entrance to the facility and available to residents and visitors. Interviews with six of six residents and three of three family/whānau members report they are informed of their rights and that staff always respect all aspects of their rights.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Abuse and Neglect policy identifies the organisation recognises all types of abuse and has processes in place to prevent and identify abuse. Policies cover spirituality and counselling and sexual behaviour in the elderly, to guide staff actions.

The environment allows residents' physical, visual, auditory and personal privacy. There are bedrooms with three beds and bedrooms with two beds. Discussions with the nurse manager, six of six caregivers and three of three family/whānau members confirm that there are areas available where residents and family/whānau can talk in private. The bedrooms with more than one bed have appropriate curtain divisions to ensure visual privacy. Residents and family/whānau consent to the sharing of the room. All residents have their own personalised areas and wardrobes to keep their personal belongings. Staff use a 'do not disturb nurse undertaking cares' sign on shared bedroom doors.

Resident's needs, values, beliefs, including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in eight of eight resident file reviews which identify interventions put in place match identified needs. All residents' religious beliefs are catered for on-site. There are Catholic communion and Anglican and Presbyterian Church services which are open to all denominations. Some residents go off site to church groups and services.

As observed at the time of audit, services are provided in a manner that maximises each resident's independence and allows choices to be respected. This is confirmed during six of six resident interviews (three hospital and three rest home level).

Residents and family/whānau report that they are treated with respect and that they receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. This finding is confirmed during 12 of 12 staff interviews.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has comprehensive guidelines for the provision of culturally safe services for Maori residents. The purpose, scope and definitions indicate culturally safe practices are documented to guide staff actions. Roles and responsibilities are set out for management and staff in relation to cultural awareness. Items to be taken into account when developing a Maori health care plan are shown in relation to all aspects of care, including death and dying and family/whānau involvement. The Treaty of Waitangi is acknowledged as the basis of good health care provision for Maori. Resident rights are printed in English and te reo Maori.

The business manager and nurse manager report that there are no known barriers to Maori accessing the service. Currently there are three residents who identify as Maori. Detailed care planning shows that none of the three Maori residents have any specific cultural requirements. This is confirmed during interview with one of the residents who identifies as Maori. The service has strong community links with a kaumātua. There are two staff who identify as Maori and one has very close links with the local marae. There is a process in place which ensures that a blessing of resident bedrooms is undertaken as required.

The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interview with 12 of 12 staff from across all services. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents.

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 Privacy and Dignity policy and procedures identify the actions taken to make sure privacy and dignity is an integral part of everyday service provision. Documentation identifies that each resident's cultural values and beliefs are respected. Policy identifies all residents' cultural needs being identified upon admission and the service ensuring all reasonable steps being taken to meet identified needs.

There is an interpreter policy in place which states a list of interpreter services contact numbers is available through the local public hospitals and can be used as required.

Interviews with six of six residents (three hospital and three rest home) and three of three family/whānau members confirm they are consulted on their/or their relatives individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family/whānau are involved in the development and review of the care planning as sighted in eight of eight resident file reviews (four rest home which includes one resident under the age of 65 years, and four hospital level).

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:

Policy and procedures are in place to ensure residents are free from discrimination, coercion, harassment, sexual, financial and other forms of exploitation.

Five of five staff record reviews identify that staff sign documentation that identifies that the staff maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory.

Interviews with 12 of 12 staff, six of six residents and three of three family/whānau members confirm they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. The nurse manager verbalises in-depth knowledge related to managing any concerns that may arise.

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:

Interviews with 12 of 12 staff from across a range of services including clinical, domestic, food and maintenance staff, confirm that the environment in which they work encourages good practice. All staff have access to up to date, evidence based policies and procedures and appropriate ongoing education. Residents usually keep their own GPs following admission and the GPs see their residents regularly. The service has established links with other local health services and general hospital specialist services.

There is regular in-service education and staff access external education that is focused on aged care. All but two newly employed caregivers hold appropriate aged care educational qualifications (ACE). Educational content is not kept for all education offered and during a discussion with the nurse manager it was agreed that this would occur from now on. (Refer comments in 1.2.7.5).

Interviews with six of six residents and three of three family/whānau members confirm they are pleased with all care delivery and the knowledge and friendliness of staff. One family/ /whānau members stated “I am so lucky that my relative is here and so well cared for”.

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:

Policies indicate that open disclosure principles are observed by the service in relation to good communication. Interviews with three of three family/whānau members confirms they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family/whānau contact is well documented in each of the eight residents' files reviewed and on all incident and accident forms sighted. The resident and family/whānau are invited to have input into six monthly care planning reviews and care planning updates.

Interpreter services are available via the local district health board as identified in policy. The nurse manager confirms that currently all residents speak English and that currently interpreter services are not required.

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:

Policy identifies that all residents admitted for long term care have their resuscitation status discussed and documented as appropriate. Family/whānau are included in the discussion if the resident agrees. There are specific forms to record the resident's wishes.

Signed consent forms are sighted in eight of eight residents' files reviewed. Informed consent is discussed prior to signing as confirmed during interview with residents and three of three family/whānau members. All files reviewed have correctly signed advance directive identifying the resident's chosen wishes related to resuscitation status. If the resident has a nominated enduring power of attorney (EPOA) for either finance and/or health decision making, a copy is located in the file. Clinical staff (the nurse manager, one EN, six caregivers and one RN) verbalise their understanding of acting on valid advance directives.

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:

Advocacy and support services information is available to staff and clearly identified in the complaints policy documentation.

Eight of eight resident file reviews and interviews with six of six residents and three of three family/whānau members confirm that the service actively encourages residents to participate fully in determining how their health and welfare is managed as appropriate. Family/whānau are encouraged to involve themselves as advocates. Contact details

for the Nationwide Health and Disability Advocacy Service is included in the information given to residents upon admission. Family/whānau members and residents confirm their awareness of where to locate the information advocacy information from the entrance to the facility. Staff interviews confirm their awareness of local advocates including local kaumātua.

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:

Interviews with six of six residents confirm they have access to visitors of their choice. Three of three family/whānau interviews confirm that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours.

Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in eight of eight resident files, observation on days of audit and interviews with the diversional therapist and six of six residents identify that regular community outings occur, residents go out with family/whānau and friends and other community services are accessed appropriately. For example residents go to local café's for coffee, go off site for church services, and have regular entertainment undertaken by local residents and groups on-site. The service also works closely with the local hospice liaison palliative care nurse when required.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)
Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)
Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)
The right of the consumer to make a complaint is understood, respected, and upheld.

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

Attainment and Risk: PA Low

Evidence:

Complaints management as described in policy identifies the procedure to be followed. Forms are available in the main entrance foyer and in the rest home and hospital lounge areas. All complaints are responded to by the manager.

A review of the complaints system identified that no complaints had been received by the facility since 2013; this was a complaint that had been received by the District Health Board. There was evidence of investigation and it was followed up with strategies, to mitigate risk. The complaint related to a fly infestation and the provider implemented automatic spray dispensers and 'fly zappers'. One of the three 'fly zappers' was in use; however two had been turned off due to the disturbance they were creating for residents. Each time the fly zappers had been emptied the maintenance man stated that they were largely filled with moths and very few flies were ever caught using this technique. Automatic spray dispensers were sighted throughout the facility and canisters are checked every two weeks by the maintenance man. The number of wheelie bins for rubbish maintained on site had been reduced and the number of collections had been increased to three times a week as a strategy to reduce fly numbers. There were no issues on site at the time of audit with flies.

No complaints register has been developed and maintained as part of the complaints management system and this requires improvement.

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: PA Low

Evidence:

A review of the provider's complaint system identified all complaints are individually stored within a clear file, however there is no register that includes all complaints, dates and actions taken. On interview the manager confirmed a complaints register had not been established.

Finding:

There is no complaints register that identifies all complaints, dates and actions taken.

Corrective Action:

To develop and implement a register that includes all complaints, dates and actions taken.

Timeframe (days): 180 *(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:

The service has a documented mission statement and philosophy showing that they are committed to the provision of quality health care to residents, family/whānau and the community.

The mission statement and philosophy for the organisation were displayed in the main foyer and are reflected in the Quality Improvement Action Plan. Objectives have been set for 2014 along with associated actions, responsibilities and target dates for completion. There is documented and physical evidence demonstrating that two objectives related to equipment have been completed with progress continuing with the remaining objectives. Clinical objectives have been documented by the Nurse Manager who was also responsible for ensuring these objectives are met.

The Business Manager has been employed with the organisation for 18 years and has had previous experience coordinating services in the education and transport sectors. A position description for the Business Manager is available electronically. The signed job description is kept off site.

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:

The staffing policy identifies that the manager is educated and experienced to take responsibility for day to day operations related to all aspects of service delivery.

The nurse manager makes staffing decisions during the absence of the Business Manager. The business manager remains contactable by phone at all times. Matters related to major financial purchases are referred to the owners for a decision. Maintenance matters are referred to the maintenance person who is able to access resources via store accounts. There is a policy (sighted) outlining responsibilities of each role which is located in the emergency planning folder.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The service has policy and procedure related to risk management and continual improvement processes. They describe how sub-optimal service standards are identified and the use of corrective actions to improve the level of service offered. Strategies and tools identified consist of audits, resident, staff and family/whānau satisfaction surveys, complaints, meetings, staff appraisals, evaluation of education and certification processes with 'Q base' (a quality improvement software).

Policies were reviewed in March 2013 and the Document Review Policy states that policies will be reviewed two yearly or sooner should there be a change to practice. An index of all policies and subsequent review dates was documented in the front of the Policy Manual.

A family satisfaction survey is in progress with positive feedback from family encountered during the audit process.

A review of the internal audit programme identified that audits were tracking to plan. Staff are allocated audits to complete and feedback the outcomes to the management team, staff interviews confirmed input at this level. Minutes of staff meetings confirmed that quality and outcome of internal audits were discussed at the meetings. Corrective actions are completed but not documented as part of the internal audit programme or complaints process. This is an area requiring improvement.

A Hazard Register is maintained and Hazard Forms list actions taken to address the issues. Actual/potential risks to residents have been identified and subsequent strategies to mitigate risk have been documented. Accident forms collect information related to health and safety issues and any essential notifications are noted and reported accordingly should they occur. The nurse manager has a process for essential notification.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)
Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)
A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

A review of the internal audit programme identified that where shortfalls in meeting the requirements were identified; corrective action plans are not developed. The issues are addressed and then discussed as part of the staff meeting, as evidenced by minutes of the meetings. Invoices were available to confirm corrective actions had been completed. Staff interviews confirmed that any issues or concerns raised are addressed and any changes are made where able.

Finding:

There is no formal documented corrective action plans developed for issues arising from audit, complaints, incidents and accidents.

Corrective Action:

Develop and implement a system to document corrective actions that address areas for improvement in order to meet standards or requirements.

Timeframe (days): 180 *(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:

Policy related to accident and incident reporting identifies that all untoward events are systematically recorded on a specific form. Response times are time lined and monitored. All incident and accident forms are presented to the health and safety committee monthly by the manager.

The Open Disclosure policy is reflective of the principles of good open disclosure practice. This is confirmed during family interviews.

The nurse manager has established a process to complete essential notifications, on interview it was established that there had been no requirement for essential notification since the last audit.

Incident and accident forms sighted are reviewed by the nurse manager before they are signed off. As part of this process the nurse manager ensures the family have been notified and checks this has been documented in the appropriate place on the form. Risks identified through internal audit are discussed at staff meetings as noted in meeting minutes, along with any actions that are being implemented to mitigate risk. Staff interviews with 12 of 12 staff confirmed they retain knowledge of how to utilise incident and accident reporting systems.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Practicing certificates were able to be sighted for all registered and enrolled nurses, there was no evidence of practicing certificates for other health care professionals and this is an area for improvement.

Five of five staff files reviewed confirmed that reference checking and orientation formed part of the process for employment. Copies of completed orientation documentation, is maintained on staff files. Five of six staff interviews identified that their tenure with the organisation has been at least 9 years or more and they had received orientation to the facility.

A programme of planned training was sighted and demonstrates that it meets the requirement of the ARRC agreement in respect of variety of core training provided. Attendance registers are maintained for in-service education; however, detail related to the topic covered is not able to be evidenced in all but two in-service education records. Staff renewals of first aid certificates are to be completed. Interviews with staff identify their knowledge in emergency/security management practices is limited to actions to be taken in a fire. Staff were not well versed in how to manage emergency situations other than fire. These are areas identified for improvement.

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: PA Low

Evidence:

Copies of current practising certificates for all Registered Nurses (RNs) and Enrolled Nurses (ENs) are maintained on site. Practising certificates for other health care professionals are unable to be validated on site.

Finding:

There is no evidence of practising certificates for GPs, podiatrists or pharmacists.

Corrective Action:

Implement a process for validating the professional qualifications for all service providers.

Timeframe (days): 180 *(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: PA Low

Evidence:

A planned programme of training was sighted and confirmed a variety of training as per the requirements of the ARRC agreement. Copies of individual staff in-service records are maintained on file. Recording of training attended is not consistently recorded with some staff having no entries since November 2013. Six of six staff interviews confirmed that it is compulsory for staff members to complete six staff meetings and six in-service education sessions per year towards meeting the requirements for their annual performance appraisals. Group attendance records are maintained for each in-service, however they do not consistently capture the detail about what the session covered in relation to the topic delivered. Renewal of first aid certificates is not completed. Interviews with staff identify their knowledge in emergency/security management practices is limited to actions to be taken in a fire. Staff were not well versed in how to manage emergency situations other than fire.

Finding:

1. The group attendance register for in-service education does not include enough detail to identify the detail of the topic covered. In May 2012, 11 staff completed CPR and ten staff completed Basic Life Support with an external consulting agency. 2. Renewal of staff first aid certificates has not been completed. 3. Recent training related to emergency/security situations cannot be evidenced; however the provider does have comprehensive policies related to the topic which staff have read at orientation. Interviews with five of five staff identified that they were not well versed in emergency and security situations, not related to fire.

Corrective Action:

1.Record the detail of what is covered in each in-service education session. 2.Complete staff renewals of first aid certificates. 3. Update staff education related to emergency/security situations.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a detailed staffing and skill mix rationale which identifies safe staffing levels. All shifts are covered by at least one registered nurse, and a review of the roster confirms staffing numbers meet the requirements of the ARRC agreement.

Staff interviews (six of six) confirmed that staff feel supported in their roles and are able to discuss concerns with senior staff/managers. At least one RN is on duty at all times, and appropriate levels of caregivers are available on each duty to meet the needs as identified on the current duty roster. Staff memos on file also confirm rationale for staffing

'up or down' as the bed numbers fluctuate. There is no evidence to demonstrate that staff with current first aid certificates are rostered each shift. Refer to comments in 1.2.7.5.

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:

Eight of eight residents' file reviews identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Entries into the progress notes records the staff member's name and designation. The current progress notes and care plan are in a separate folder from the resident's main file, although these files demonstrate integration of the records with the progress notes then filed in the main clinical folder. The eight of eight residents' files reviewed evidence that all records pertaining to individual residents are integrated.

All information is up to date and easily identifiable and accessible for staff and other health care providers. Files that are not current are stored securely.

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:

Entry criteria are documented and the service accepts resident who have been assessed by a needs assessment agency for either hospital or rest home level care. The nurse manager confirms the service has a very good relationship with the local needs assessment agency who are aware of the level of care they offer. The service notifies bed status daily via Eldernet so that all agencies are aware of any vacancies that are available.

When a resident applies for entry to service the nurse manager or the business manager check that the correct level of care is shown on the admission request form. If an application is made for a level of care not offered information is given to the person making the request related to the correct process and other facilities in the area.

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 nurse manager and business manager report that no residents who meet the entry criteria have been declined if a bed is available. They understand that if a resident was to be declined entry other options or alternative service information would be offered to the applicant or their family/whānau.

The admission agreement is based on the New Zealand Aged Care Association Agreement. The admission agreement sighted describes information related to termination of agreement.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Policy identifies all resident assessment, planning and evaluation of care is undertaken by a registered nurse. The service has not yet commenced the use of the interRAI assessment, but one RN has successfully completed her training. The current paper based initial assessments includes the physical, psycho-social, spiritual and cultural needs of the residents. The initial nursing assessment, includes breathing, elimination, nutrition, sensory, hygiene and grooming, skin integrity, communication, sleep/rest, mobility, spiritual/cultural/emotional, social, pain and a summary of problems and the interventions that will be put in place. Over a three week period assessment tools, including Coombes fall risk, Braden scale skin integrity, pain, food and nutritional, continence, and restraint, as appropriate, are used to inform long term care planning for the resident. All residents care plans are reviewed at a minimum of six monthly via a multidisciplinary review process. Assessment, planning evaluation and review are undertaken by a RN. Caregivers provide daily care management with RN/EN oversight.

An acute care plan (short term) is put in place for infections, loss of skin integrity and/or a sudden change in the resident's condition. Short term care plans identify the problem, outcome, treatment and are signed off when treatment is completed. If an issue is determined not to be completed within a reasonable amount of time, such as one month the issue is then entered onto the resident's long term care plan.

The residents are reviewed routinely by a general practitioner (GP) at last three monthly. In all eight of eight resident file reviews there is a statement to say that the resident is stable and can be seen three monthly.

A daily record of care (progress notes) is written for each hospital level resident and rest home level care residents have progress notes written from Monday to Friday. Entries are only written up on the weekends if there is anything out of the usual to report. Any concerns or issues are clearly documented. There is a verbal handover between each shift and a documented handover sheet is located in the office. The handover sheet is accessible to all staff; it highlights any changes to care or any concerns. A diary is used to record any general issues, such as appointments. Interviews with six caregivers, one EN and one RN confirm all information related to resident care is clearly documented and communicated during the handover process.

Tracer one example

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

Tracer two example:

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

Tracer three example

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service implements clinical policies to ensure all residents' needs are ascertained and monitored via an approved assessment process. The tools sighted include continence, hygiene and personal grooming, Braden scale pressure area care falls, wound management, pain, social activity and restraint as required. The resident's needs, outcomes and goals are clearly identified during the assessment process and information is used to inform care planning processes.

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:

Eight of eight residents' files reviewed (four hospital and four rest home level) identify that care planning is individualised to reflect resident's assessed needs and interventions are clearly shown. Input from all health care providers and the assessment process inform care planning which is congruent with findings. Three of the eight file reviews were undertaken confirm care planning covers unexpected changes to residents' needs as well a meeting residents' everyday needs. All interventions are detailed and clinical staff interviews confirm the information ensures continuity of care. Interviews with six of six residents and three of three family/whānau members report all care is provided to meet their needs by staff who have the knowledge and skills to manage all cares.

Residents have one main folder that contains their medical information, completed progress notes, previous care plans and evaluations and correspondence including off site consultation. On an everyday basis staff use a folder containing current progress notes, the current care plan, routine observations, activities, therapies, and the current multidisciplinary review. Staff interviews confirm they can access all notes when required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures in place to guide staff actions related to all aspects of care such as continence management, challenging behaviour, pain management, personal hygiene and grooming, skin and wound management, care of the dying and falls management.

The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. Eight of eight care plan reviews confirm care planning is individualised and personalised to be a true reflections of resident's assessed needs. Observation on the days of audit identifies that care is resident centred and residents are given choices of times and type of care interventions. All care provision is overseen by the RNs and closely monitored by the nurse manager.

Interviews with six of six caregivers confirm they use the information documented on residents' care plans to ensure the interventions they provide are appropriate to meet each resident's needs. If an intervention is not working well it is reported to the nurse manager and the resident's progress and interventions are re-evaluated.

Six of six residents and three of three family/whānau interviews confirm they are very satisfied with care and interventions provided by the service. There were no negative comments received during any interviews on the days of audit. Family/whānau members voiced their satisfaction with having a service provided locally which meets all their relative's needs.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Activities are planned and facilitated to develop and maintain resident strengths, skills and interests. This is confirmed by observation on the days of audit, during six of six resident interviews and as documented in eight of eight resident files. Annual planning occurs for set items, such as days of celebrations, Mothers' day or regular visits to community shows or clubs.

The diversion therapist undertakes a resident profile related to past and present activity likes and interests to ensure activities are meaningful for individual residents. One example relates to a resident with memory loss who had painting as a previous hobby. The service provides all the material and a safe place for the resident to maintain this as observed on the days of audit. Weekly planning occurs to encompass weather conditions, special events and daily activities. This includes regular outings, inter-rest home men's visits to local workmen's clubs and entertainment. The activities programme caters for all acuity and age ranges at the facility. Resident's cultural needs are also included into the activities programme, such as the celebration of Matariki.

There are regular onsite church services to cover all known resident denominations. Some residents choose to go off site to their local church and they are assisted by the service to do this as required.

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:

Six of six residents and three of three family/whānau interviews confirm that they have a good level of satisfaction with the care provided at the service and that they feel fully involved and informed related to care planning and interventions that are put in place. Family/whānau report that communication is very good and all evaluation process are explained in a manner that they understand.

A review of eight of eight residents' files, consisting of four hospital and four rest home level care residents, including one young person under the age of 65 years, was undertaken. Resident care interventions are reviewed at least six monthly or where progress is different from expected the care plan is updated. The six monthly multidisciplinary review shows that all care is measured using a number system to show if interventions are working. If a resident's condition is seen to be deteriorating or their needs are not being met the care plans are updated. The evaluation process identifies any required changes but regular evaluation findings are not shown on the care plan. This was discussed with the nurse manager who will ensure the date of each evaluation is shown on the care plan to make it easier to see for staff employed on a casual basis.

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:

Referrals are made to other medical service by the nurse manager or GP as appropriate. Records of referrals are sighted in eight of eight residents' file reviews. Health services accessed include general medicine, surgical services, radiology, ophthalmology, physiotherapy, podiatrist, dermatology, dental care, gerontology nurse specialist and the wound care nurse specialist.

One resident reviewed for hospital level care had it clearly documented in their file that they were offered but refused specialist input into a skin problem they have. This clearly indicates that resident choices are sought and respected by the service.

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:

Risks are identified prior to planned discharge as identified on the discharge forms used. The service uses an approved Waikato District Health Board form when transferring to general hospital and a San Michele specific form is used when transfer is undertaken to another care provider. The forms identify any known risks or concerns so the resident can be managed safely. The nurse manager confirms there is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family/whānau or resident want discussed, these are noted on the transfer form. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a full suite of medication management policies, procedures and protocols. This includes an 'INR' protocol. Policy states that administration of medication is undertaken by registered or enrolled nurses only. The documented medicine management processes comply with legislative requirements and current safe practice protocols and guidelines. This includes resident self-administration of medicines. The nurse manager confirms there are currently no residents who self-administer medication.

The Medico Pak system is used at the facility. Processes in place to ensure safe medication management include checking systems when medication is delivered to the facility from the pharmacy and the annual ongoing competence testing of RNs and ENs who administer medicines. Up to date competencies are sighted in staff files for those who require them.

Medicines that are not packed, such as liquid medicines, are individually supplied for each resident. The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly thereafter. This process is not always documented on the resident's medication chart and is an area for improvement. The pharmacy undertakes reconciliations of medicine charts each time a chart is rewritten. It was discussed with the nurse manager that this process could be improved by ensuring pharmacy reconciliations are undertaken as part of the resident's six monthly multidisciplinary reviews. The facility will investigate this option.

All medicines and the medicine trolley are stored in the locked medication room. The medicine fridge is monitored for temperature daily, with the sighted temperatures within safe medicine storage guidelines. Controlled drugs are stored in a safe in the medication room and are signed out by two staff when given. A weekly stock count is recorded in the controlled drug register. Sample signature verification is recorded in the front of the medication file but each individual resident signing sheet has an area for staff signatures which is not completed. This is an area identified for improvement

A review of 12 of 12 medicine charts identify that each medication is signed for by the GP. All prescriptions are computer generated by the pharmacy and they allow safe medication administration process to be undertaken by staff. The prescriptions are legible and record the name, dose, route, strength and times for administration. Short term medication has a start and stop date. 'PRN' (as required) medications are closely monitored and if they are required on a regular basis, staff ensure the GP undertakes an assessment and changes the PRN medication to regular medication. All the medicine charts sighted identify resident allergies and have a current photograph of the resident for identification purposes. The service has standing orders in place which do not meet all the current legislative and best practice standards related to maximum dose recording. This is an area identified for improvement. The charge nurse stated that standing orders are not used often.

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 Low

Evidence:

A review of 12 medication charts and the observation of a medicine administration round were undertaken. Two of the 12 resident charts reviewed do not have GP three monthly reviews signed for. Nursing staff who administer medicines do not use the signing block on the medicine charts to identify their signatures. Standing orders do not state who may administer them and the maximum dose is not always identified.

Finding:

Two of the 12 resident charts reviewed do not have GP three monthly reviews signed for. Nursing staff who administer medicines do not use the signing block on the medicine charts to identify their signatures. Standing orders do not state who may administer them and the maximum dose is not always identified.

Corrective Action:

Ensure medicine management information is recorded to a level of detail to comply with legislation and guidelines.

Timeframe (days): 180 *(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:

There are policies and procedures in place related to good hygiene and kitchen practices including safe food handling and correct food storage.

The menu is reviewed by a registered dietitian in August 2014 and states it is suitable for aged care residents. The recommendations sighted on the dietitian review have yet to be implemented by the service.

Every resident has a dietary profile undertaken by a RN upon entry to the service and all residents are routinely weighed at least monthly, or more frequently when indicated. This is confirmed in eight of eight resident file reviews. Residents with additional or modified nutritional needs or specific diets have these needs assessed by the dietitian and the GP and all dietary needs are met by the service. Kitchen staff are aware of each resident's dietary needs and resident profiles are kept in the kitchen. One resident has an egg allergy which is clearly identified in the kitchen and known by kitchen staff. Interviews with six of six residents confirm they are very happy with the food service and that their likes and dislikes are catered for. Three of three family/whānau members state their relative have no complaints about the food.

Residents sighted being fed were up in chairs and correctly positioned.

All aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. Expiry dates for decanted dry foods can be traced using the bulk ordering system which is computerised. A discussion with the business manager and the cook was undertaken related to not decanting produce but to place dry goods in bins in their original bags. The service will consider this action.

During an interview with the cook and in staff file reviews, it is confirmed that kitchen staff have completed food safety qualifications, are that they are offered ongoing education as appropriate.

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:

Policy covering waste disposal covers infectious and hazardous substances. Medical waste sharps disposal containers are located in the clinic. All medical waste is disposed of in accordance with infection control practices in order to minimise the risk of unnecessary exposure.

Medical waste is separated into yellow bags and collected as required by a medical waste collection service. General waste is deposited in large green bins which are emptied 3-4 times a week. Sharps containers are available for the disposal of sharps. The number of green wheelie bins has been reduced to mitigate the risk of flies and they are now collected 3 times a week.

Gloves were sighted in each bedroom and strategic locations throughout the facility. Supplies of disposable aprons were located in the sluice room along with heavy duty aprons that are used when sluicing soiled items. Staff were noted to be wearing/utilising personal protective equipment (PPE) throughout the duration of the audit. Staff interviews also confirmed use of PPE.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The building warrant of fitness on display in the main foyer has an expiry date of 12 June 2015. The facility was well worn and a maintenance plan was sighted that identified plans for ongoing refurbishment. Testing and tagging of electrical equipment has been completed (next due March 2015) and medical equipment has been calibrated. Four unrestrained oxygen bottles were sighted in the clinical room and this is an area identified for improvement. The maintenance man has a log book (sighted) of all checks completed and dates for future checks. Water temperatures were within accepted limitations with plumbers called should adjustments be required. A complaint sighted identified that one resident was not happy for the wallpaper in their room to be changed despite it being old; they had chosen the wallpaper years prior and would prefer to retain it as a personal choice. Interviews conducted with six staff acknowledged the building was old but raised no concerns related to the facility.

The front entrance has stairs with a hand rail; however ramps are available back and front of the facility to assist residents with mobility issues to access/exit the building. Lounge space was available in two areas of the facility and an alternative quiet area was available, with access to a telephone for resident use. A supply of spare walking frames and equipment are stored in the maintenance shed and were in the process of being culled to ensure only the most appropriate equipment was stored on site.

There are an adequate number of showers and toilets to meet the needs of residents; non-slip flooring was sighted in each bathroom. Facilities in one shower were noted to be in poor condition related to the integrity of the wall lining and rusting equipment this was an area identified for improvement.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

Railings are available to assist with safety when mobilising. Corridors are wide enough to facilitate access throughout the facility. A ramp at the rear of the facility also acts as an emergency exit, allowing an unimpeded route through to the neighbour's yard which is used as an assembly point. Garden areas are accessible and shaded areas are available under trees.

Heaters have been located up higher on the wall which reduces potential risk to residents.

Four unrestrained oxygen bottles are stored in the clinical room and this is an area identified for improvement.

Non slip floors are present in each shower and railings for assistance are available. Walls in one of the showers are chipped and is a potential infection control risk. There is rusted equipment in one of the bathrooms.

Finding:

(1) Unrestrained oxygen bottles pose a risk to residents and staff. (2) The wall board in one shower is chipped at the bottom and poses an infection control risk. (3) Metal framing and equipment in one bathroom is rusted.

Corrective Action:

Ensure all oxygen bottles are securely restrained at all times. Ensure equipment and environment surfaces are able to be easily cleaned.

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

Criterion 1.4.2.6 (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 an appropriate number of showers and toilets accessible to residents. Privacy curtains are available within each shower area and privacy locks are on the doors. Visitor and staff toiles are separate to those of the residents.

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 are sufficient space in personal areas to allow for mobility equipment. Residents are able to personalise their space and appropriate drawers and wardrobes are available to residents for personal storage. Electric beds are available as appropriate for the resident's needs. No negative comments were received from residents on the days of audit related to their personal bedroom space.

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 facility was built in the 1930s and is now showing its age. The provider has a plan to redecorate some areas of the facility. There is one complaint from 2007 where a resident (still in residence) laid a complaint, as they do not want their wallpaper changed. Appropriate dining and recreational areas are available to residents. Access to a phone in a quiet area is easily accessible. Office space is provided to residents and families that wish to discuss matters in privacy.

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: PA Low

Evidence:

There are well set out goals and objectives for domestic services. Cleaning and laundry procedures are clearly set out including body waste precautions related to spills.

The cleaner's trolley includes a locked box for storage of chemicals and when not in use the trolley is locked in a secure cupboard. One of two storage cupboards containing chemicals in the sluice room is not locked. One cupboard in the kitchen containing chemicals is not locked. A bottle of laundry detergent sits on the floor next to the washing machine and there is no lockable door on the laundry. The reduced mobility of the residents does mitigate the risk partially; however there is no fence between the neighbours and the open laundry. The access to the laundry liquid is also a potential hazard to visiting children. This is an area identified for improvement.

All chemicals are clearly labelled to identify contents. Internal audits are completed of the cleaning process. The chemical supplier visits regularly and monitors dosage rates and adjusts accordingly. Staff have received training in the use of the new chemicals and the domestic supervisor provides "just in time" and "one on one" training where needed. Internal audits are completed of the cleaning process.

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: PA Low

Evidence:

One of two storage cupboards containing chemicals in the sluice room is not locked. One cupboard in the kitchen containing chemicals is not locked. A bottle of laundry detergent sits on the floor next to the washing machine and there is no lockable door on the laundry. The reduced mobility of the residents does mitigate the risk partially; however there is no fence between the neighbours and the open laundry. The access to the laundry liquid is also a potential hazard to visiting children. All chemicals are clearly labelled to identify contents.

Finding:

Unsecured chemicals are identified within the facility.

Corrective Action:

All chemicals must be stored safely in a secured area.

Timeframe (days): 180 *(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: PA Low

Evidence:

The provider has an approved fire evacuation plan; the letter sighted is dated 26 July 1999. Staff have have in-depth training related to fire. The last fire evacuation was due in June 2014, this has been missed due to an external provider not being available. Emergency lighting, food supplies and gas cooking facilities are adequate to meet the immediate need in an emergency. The provider has approximately 40 litres of water stored which is inadequate to meet the recommended volumes per resident in a civil defence emergency. These are areas identified for improvement.

The call bell system was tested and found not to work on the initial test, this was rectified immediately by turning the switch back on. Routine security checks are completed by staff to ensure the building is secure, particularly at night.

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: PA Low

Evidence:

The provider has had detailed training related to fire. The fire evacuation drill that was due in June has not been completed.

Finding:

The fire drill due in June 2014 has not been completed.

Corrective Action:

The overdue Fire Evacuation Drill is to be completed.

Timeframe (days): 180 *(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:

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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: PA Low

Evidence:

Emergency lighting, food supplies and gas cooking facilities are adequate to meet the immediate need in an emergency. The provider has approximately 40 litres of water stored which is inadequate to meet the recommended volumes per resident in a civil defence emergency.

Finding:

There is insufficient water stored to meet the required 3 litres of water per person per day for three days.

Corrective Action:

Ensure there are adequate water supplies to meet the recommended amount of 3 litres of water per person per day for 3 days.

Timeframe (days): 180 *(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:

A review of the facility confirmed that all personal and living spaces had at least one external window to enable the room to be naturally lit. Staff open doors and windows during the day for ventilation of the facility. A range of gas and electrical heating is utilised throughout the facility. In areas that were occupied the temperature was comfortable for the residents. A supply of knee rugs was available and utilised to warm up a resident who had been out for a walk with family during the afternoon.

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:

Policy identifies that the facility promotes a restraint-free environment. The definition of an enabler identifies that this option is voluntary and the least restrictive.

All items in use are listed as restraints; there are no enablers in use. Items in use are bed rails, lazy boys, harnesses and lap belts. A review of 8 resident files confirms there are documented three monthly reviews to ensure that the least restrictive and most appropriate method is being utilised. Eight restraint monitoring forms reviewed confirmed that restraints were only utilised where necessary and for as short a time as possible, forms included monitoring time frames. Documentation confirmed restraints were removed for periods of the day i.e. when the resident was up in a chair. Interviews with four staff confirmed that restraint was used only in situations related to maintain the safety of the resident.

Interview with management confirmed that no enablers were utilised within the facility. The restraint register only had restraints listed and there are no enablers on the list.

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 practices described identify the approval process, cultural considerations, assessments, monitoring, evaluation and risk and quality management. Identified restraints are lap belts, bedside rails, harness and lazy boy chairs. The restraint co-ordinator is a RN and the resident's GP is involved in the signing off any decision to implement restraint. The outcome of the assessments and the associated implications are discussed with the staff. Interviews with four clinical staff confirmed they have input into assessment, evaluation and monitoring processes.

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 assessment tool covers all required aspects to meet the standard. A review of eight resident's files confirmed that assessments had been completed, assessments took into consideration points (a) to (h). Interview with one manager confirmed the assessment process and how it was implemented.

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: PA Low

Evidence:

The restraint assessment checklist and evaluation identifies safe restraint practices. Policy indicates there is an up to date register of all restraint use. Completed forms confirm that the GP and the nurse manager and family are involved in the approval process. Monitoring forms largely record the detail related to application and removal of restraint along with activities of daily living (ADLs) that are completed. Afternoon shift consistently record ‘a dash’ in the boxes rather than actual data; this related to one staff member. A restraint register is held on site and maintained by the nurse manager, this is stored with the monitoring forms.

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: PA Low

Evidence:

A sample of eight files were reviewed and it is noted that an individual staff member is not clearly documenting the application and removal of the restraint, entering dashes instead of words/numbers. The Clinical Manager addressed this with the staff member when they arrived on duty.

Finding:

Documentation does not accurately reflect the time or action that had taken place.

Corrective Action:

Ensure all documentation accurately reflects the monitoring of the restraint.

Timeframe (days): 180 *(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:

Policy identifies that evaluation is undertaken for each restraint episode to see if the intended outcome of keeping the resident safe has been achieved. Based on the evaluation outcome it is decided if restraint is to be continued. Resident, relatives and staff are included in the restraint evaluation process and (a) to (k) is considered in the process. Eight resident's files were audited and there is clear evidence documented in the files of three monthly reviews having occurred for residents with restraints. Restraint monitoring forms (eight reviewed) demonstrate that restraint is applied for only the period necessary to keep the resident safe. Staff interview with four staff confirmed they provided feedback to towards restraint evaluation.

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:

Policy states that the quality review includes regular checking that restraint techniques and staff training remain appropriate to reflect current best practice and comply with standards. Reviews are completed by the restraint approval group and includes (a) to (h) as outlined in this criterion and are used to improve services as appropriate. Interview with the nurse manager confirmed that staff are asked for input at review times to ensure all sources of information are considered in future restraint use. Outcomes of reviews are used to make necessary changes to the care plan where applicable. A review of eight resident's files confirmed changes are made to care plans and time frames for monitoring were documented on each Restraint Monitoring Form. There is training records evidencing that staff completed training related to challenging behaviour on the 24 April 2014. The training record lacks detail about the content covered for each session; this has been identified as an improvement required at criterion 1.2.7.5. Staff interview of four of four staff confirm that they have completed training and are involved in the monitoring of residents.

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 is a suite of policies and procedures and an infection control programme that is appropriate to the size and scope of service offered. It is reviewed annually. The responsibility for infection control is that of either the nurse manager or the designated RN. All staff members must take responsibility for ensuring they adhere to policies and procedures. The infection control coordinator (ICC) is supported by the quality person who undertook this role for many years prior to her new appointment. There is an ICC job description in place which identifies clear lines of responsibility and accountability for all infection control matters within the service.

Infection control is a standing agenda item on staff meetings and staff are kept fully informed of types and numbers of infections on a monthly basis. This is confirmed during 12 of 12 staff interviews.

Notices are sighted asking visitors not to visit if they are unwell. The infection control programme sighted is appropriate to the size and scope of the service.

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 service has a nominated infection control coordinator who is responsible for the collation of all reported infections. The collated information is shared with all staff and any concerns are escalated to the business manager who alerts the owners if required. The ICC has access to persons with a range of skills, expertise and resources via Waikato DHB and external specialist infection control providers to ensure the documented goals for the infection control programme can be maintained. The ICC is a member of the

local area infection control group who meet bi-monthly. The ICC confirms that the service also has access to external advice through the GP, product supplier, specialist infection control contractors, DHB and Ministry of Health services as required. The ICC reports they have adequate human, physical and information resources to implement the infection control programme.

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:

Policies and procedures sighted comply with relevant legislative and current accepted good practice processes.

The ICC confirms policies were reviewed and updated in 2014. There are very clear guidelines for defining infection for surveillance and all information is readily available to all staff in the nursing office. Interviews with 12 of 12 staff from across the service confirm they understand and implement policies and reported as required and that all infection control data is shared at staff meetings.

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:

It is identified that staff undertake appropriate education including hand washing techniques and the appropriate use of personal protective clothing and equipment. Pandemic and outbreak management is documented.

Infection control education is provided by the ICC who maintains her knowledge of current practice. Staff attendance at Waikato DHB infection control training is identified for the ICC, quality advisor and one RN. All clinical staff have attended infection control education provided by an outside provider in July 2014. This included standard precautions and hand washing. Staff confirm their education is understandable and related to the role they are employed to undertake. Resident education is provided informally during cares, such as wound care and catheter cares.

An audit undertaken in March 2014 identifies that all staff have completed an infection control questionnaire which is an annual requirement. Findings from the audit show that a request for additional hand sanitising gel was declined as there have been no outbreaks and the ICC feels that there are enough existing sanitizing gels to meet the facility needs.

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:

Policy states the process of data collection, collation and analysis is undertaken for the purpose of characterising risk groups and identifying control strategies. Feedback of data is disseminated to all staff.

The infection control programme that is in place meets all Health and Disability Services Standards and Infection Prevention and Control guidelines and requirements in relation to the type and amount of data collected. The ICC accesses all infection control information collected within the service and has sufficient resources and systems to collate the information. All infections are recorded on infection report forms, collated once a month, analysed and action taken when required.

An increase in chest infections was recorded for June, July and August 2014 and during discussion with the nurse manager it was agreed she is misreporting some infections and that unresolved infections are being reported twice. This increase in infection numbers has been discussed with staff and at the RN meetings and appropriate corrective actions have been put in place. Actions include additional fluids being given and correct positioning of residents when being fed. This is traceable via staff meeting minutes.

The annual review of the infection control programme sighted was undertaken in September 2014 by the ICC. This information is presented to senior staff including the business manager.

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.)*