Ngati Porou Hauora Charitable Trust Board

Current Status: 3 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

Ngati Porou Hauora Charitable Trust provides medical, long term care (geriatric) and maternity services for the community. Admission occurs through a referral process from one of the community health centres or directly through the emergency department. The service has a total of twenty beds with occupancy of ten patients at the time of this audit.

A range of quality initiatives are implemented and the services are moving towards continuous improvement activities. There are no areas for improvement identified in this audit.

Audit Summary as at 3 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
	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 3 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.		Standards applicable to this service fully attained.

Organisational Management as at 3 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.		Standards applicable to this service fully attained.

Continuum of Service Delivery as at 3 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.		Standards applicable to this service fully attained.

Safe and Appropriate Environment as at 3 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.		Standards applicable to this service fully attained.

Restraint Minimisation and Safe Practice as at 3 September 2014

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

Infection Prevention and Control as at 3 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 3 September 2014

Consumer Rights

Staff interviewed demonstrate an understanding on how the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` rights (the Code of Rights) is

implemented into everyday practice. Patients report they receive services in line with their rights and that they are treated with dignity, respect and feel safe and secure at all times. Privacy and confidentiality needs are considered. Provisions for meeting spiritual needs and promoting a safe environment for patients are effectively met.

The cultural care policy and the kaupapa cultural safe care policies were reviewed. The service's commitment is clearly documented and details how this is to be achieved. The Maori health plan includes the vision, mission and planning for the organisation inclusive of the values and strategic directions to be met. Cultural values and beliefs are taken into consideration at all stages of service delivery. A kaumatua is available and accessible for patients and family/whanau if required.

The informed consent processes, scope and purpose meets the obligations of the Code and legislative requirements are clearly documented in relation to informed consent. The service has a policy documented and implemented on open disclosure and communication is evident between the registered nurses and the four medical officers, one of whom was interviewed. An independent advocacy and support service is available.

Unexpected events are responded to appropriately and whanau/next of kin notified as they have requested. A record is kept on a patient's file of all such contact.

There is a complaints process which is easily accessed throughout the building. The complaints register is maintained by the quality coordinator. This is up-to-date and includes all actions taken in response to complaints and meets the requirements of the Code of Rights.

Organisational Management

Ngati Pourou Hauora has a senior management team which reports to Te Runanganui O Ngati Pourou. There are systems which monitor the performance of the organisation. The chief executive has a background in the health sector and has worked at the hospital in the past. She is supported in her role by a hospital manager and a primary health manager. There is a clinical director who is registered medical practitioner.

There are appropriate succession plans in the temporary absence of any of the senior management team. The ward is managed by a clinical nurse manager and the maternity service by a midwife team leader who has dedicated support from the community lead maternity carer to ensure this aspect of service delivery is effectively covered.

The organisation has a quality management system which is overseen by the quality coordinator with each manager responsible for implementation in their area. There are document control and management systems. In the last 18 months an electronic system has been utilised increasing the reliability of the system. There are effective procedures for the collation and analysis of quality improvement data, monitoring progress against the organisation's quality plan, and for clinical governance. Adverse events are reported and recorded and staff members understand their responsibilities in relation to this.

Human resources management procedures are implemented at Ngati Porou Hauora. There is low staff turnover at the hospital. Managers are responsible for completing the orientation programme for new staff. The programme of ongoing education meets the requirements of these standards and provides sound professional development for all staff members.

Each resident and woman using the maternity unit has an individual record of their care and support. This is current and is maintained confidentially in a secure location. Staff maintain timely, accurate records in relation to all people using the hospital's services.

Continuum of Service Delivery

The patients, family/whanau and the medical officer interviewed express a high level of satisfaction with the quality of care and services provided at Te Puia Springs Hospital. The service has policies and processes related to entry into each respective service.

All services are provided by suitably qualified and trained staff to meet the needs of the patients. The patients admitted to the ward have an initial nursing assessment and the care plans are developed by the registered nurses. For the long term care patients this occurs three weeks after admission and the care plans are reviewed six monthly or more often if required. Patients confirm interventions are noted in their service delivery plans and are consistent with meeting their needs.

The medical patients after the initial assessment is performed, an admission to discharge planner is developed on admission which is reviewed on a daily basis. For the long term care patients medical reviews occur three monthly, or earlier if required.

The maternity service records are documented accurately and to a high standard. Partners and/or support persons of the women's choice, and with their consent, are welcome during labour and at the birth.

The service has an activities plan for the long term care patients and other patients are welcome to attend. Independence is encouraged. Staff assist with the activities to meet the needs of the patients.

A team approach to care is encouraged and continuity of care is evident in the patients' records reviewed.

The medication management system is safely managed. The registered nurses and midwives are responsible for medicine management in their respective services. All staff responsible for medication management are assessed as competent and receive ongoing education. The midwives are able to prescribe within their scope of practice. The medication for the long term care area is blister packed and the system is working effectively. Legislative requirements are met and policies, procedures and appropriate guidelines are available for staff.

Food and nutrition needs are well managed by the cook and kitchen staff. There is safe and hygenic storage of all food and supplies. There is oversight of menus by a dietitian and those people who require modified diets have these provided for them by kitchen services. The kitchen supplies both the ward and maternity unit with nutritious meals, but also operates a staff canteen and provides catering services when required.

Safe and Appropriate Environment

The environment at the hospital is maintained well. There are procedures for the management of waste and hazardous substances and staff members follow these. There are sufficient supplies of protective equipment. Cleaning products are provided by a reputable supplier and monitored for effectiveness.

There is a current building warrant of fitness. Annual electrical safety checks of both clinical and non clinical equipment are completed. There are monitoring processes for other building systems including hot water temperature in rooms used by patients and in the maternity unit, emergency signage and lighting, fire evacuation practices and fire suppression equipment.

There are sufficient bathrooms and toilets to meet patients' needs and additional facilities for staff and visitors. Rooms are spacious and allow for movement and mobility. There is adequate heating, ventilation and natural light.

The organisation has appropriate emergency, essential and security systems in place. There are alternative power and cooking sources in the event of an emergency.

Restraint Minimisation and Safe Practice

The organisation has appropriate policies and procedures to guide staff in the use of restraints and enablers should these be assessed as necessary. At the time of the audit there are no restraints in use in the facility.

Enabler usage includes an assessment of need, consent by the resident and/or whanau, monitoring when in use because of the type of enabler, and reassessment due to the short term nature of the need.

Infection Prevention and Control

The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to patients, staff and visitors. Policies and procedures are aligned with current accepted good practice. There are adequate resources to allow for a managed environment, which minimises the risk of infection. The programme is relevant to the size and scope of services provided and is monitored by the facility's clinical nurse manager who has the role of infection control co-ordinator. Antimicrobial practice for all three services (medical, long term care and maternity) is monitored. Monthly surveillance data is recorded, collated and reported to management and staff. Analysis and evaluation of data is used for quality improvements, which are monitored in a timely manner.

HealthCERT Aged Residential Care Audit Report (version 3.92)

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:	Ngati Porou Hauora Charitable Trust Board
Certificate name:	Te Whare Hauora O Ngati Porou

Designated Auditing Agency:	DAA Group Ltd

Types of audit:	Certification
Premises audited:	Te Puia Springs Hospital
Services audited:	Hospital Care – Medical – Geriatric and Maternity. Rest Home.
Dates of audit:	**Start date:** 3 September 2014 **End date:** 4 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:	10

Audit Team

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

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

Sample Totals

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

Number of residents interviewed	7	Number of staff interviewed	10	Number of managers interviewed	4
Number of residents' records reviewed	10	Number of staff records reviewed	10	Total number of managers (headcount)	5
Number of medication records reviewed	20	Total number of staff (headcount)	101	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA 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 has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Tuesday, 7 October 2014

Executive Summary of Audit

General Overview

Ngati Porou Hauora Charitable Trust provides medical, long term care (geriatric) and maternity services for the community. Admission occurs through a referral process from one of the community health centres or directly through the emergency department. The service has a total of twenty beds with occupancy of ten patients at the time of this audit.

A range of quality initiatives are implemented and the services are moving towards continuous improvement activities. There are no areas for improvement identified in this audit.

Outcome 1.1: Consumer Rights

Staff interviewed demonstrate an understanding on how the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` rights (the Code of Rights) is implemented into everyday practice. Patients report they receive services in line with their rights and that they are treated with dignity, respect and feel safe and secure at all times. Privacy and confidentiality needs are considered. Provisions for meeting spiritual needs and promoting a safe environment for patients are effectively met.

The cultural care policy and the kaupapa cultural safe care policies were reviewed. The service's commitment is clearly documented and details how this is to be achieved. The Maori health plan includes the vision, mission and planning for the organisation inclusive of the values and strategic directions to be met. Cultural values and beliefs are taken into consideration at all stages of service delivery. A kaumatua is available and accessible for patients and family/whanau if required.

The informed consent processes, scope and purpose meets the obligations of the Code and legislative requirements are clearly documented in relation to informed consent. The service has a policy documented and implemented on open disclosure and communication is evident between the registered nurses and the four medical officers, one of whom was interviewed. An independent advocacy and support service is available.

Unexpected events are responded to appropriately and whanau/next of kin notified as they have requested. A record is kept on a patient's file of all such contact.

There is a complaints process which is easily accessed throughout the building. The complaints register is maintained by the quality coordinator. This is up-to-date and includes all actions taken in response to complaints and meets the requirements of the Code of Rights.

Outcome 1.2: Organisational Management

Ngati Pourou Hauora has a senior management team which reports to Te Runanganui O Ngati Pourou. There are systems which monitor the performance of the organisation. The chief executive has a background in the health sector and has worked at the hospital in the past. She is supported in her role by a hospital manager and a primary health manager. There is a clinical director who is registered medical practitioner.

There are appropriate succession plans in the temporary absence of any of the senior management team. The ward is managed by a clinical nurse manager and the maternity service by a midwife team leader who has dedicated support from the community lead maternity carer to ensure this aspect of service delivery is effectively covered.

The organisation has a quality management system which is overseen by the quality coordinator with each manager responsible for implementation in their area. There are document control and management systems. In the last 18 months an electronic system has been utilised increasing the reliability of the system. There are effective procedures for the collation and analysis of quality improvement data, monitoring progress against the organisation's quality plan, and for clinical governance. Adverse events are reported and recorded and staff members understand their responsibilities in relation to this.

Human resources management procedures are implemented at Ngati Porou Hauora. There is low staff turnover at the hospital. Managers are responsible for completing the orientation programme for new staff. The programme of ongoing education meets the requirements of these standards and provides sound professional development for all staff members.

Each resident and woman using the maternity unit has an individual record of their care and support. This is current and is maintained confidentially in a secure location. Staff maintain timely, accurate records in relation to all people using the hospital's services.

Outcome 1.3: Continuum of Service Delivery

The patients, family/whanau and the medical officer interviewed express a high level of satisfaction with the quality of care and services provided at Te Puia Springs Hospital. The service has policies and processes related to entry into each respective service.

All services are provided by suitably qualified and trained staff to meet the needs of the patients. The patients admitted to the ward have an initial nursing assessment and the care plans are developed by the registered nurses. For the long term care patients this occurs three weeks after admission and the care plans are reviewed six monthly or more often if required. Patients confirm interventions are noted in their service delivery plans and are consistent with meeting their needs.

The medical patients after the initial assessment is performed, an admission to discharge planner is developed on admission which is reviewed on a daily basis. For the long term care patients medical reviews occur three monthly, or earlier if required.

The maternity service records are documented accurately and to a high standard. Partners and/or support persons of the women's choice, and with their consent, are welcome during labour and at the birth.

The service has an activities plan for the long term care patients and other patients are welcome to attend. Independence is encouraged. Staff assist with the activities to meet the needs of the patients.

A team approach to care is encouraged and continuity of care is evident in the patients' records reviewed.

The medication management system is safely managed. The registered nurses and midwives are responsible for medicine management in their respective services. All staff responsible for medication management are assessed as competent and receive ongoing education. The midwives are able to prescribe within their scope of practice. The medication for the long term care area is blister packed and the system is working effectively. Legislative requirements are met and policies, procedures and appropriate guidelines are available for staff.

Food and nutrition needs are well managed by the cook and kitchen staff. There is safe and hygenic storage of all food and supplies. There is oversight of menus by a dietitian and those people who require modified diets have these provided for them by kitchen services. The kitchen supplies both the ward and maternity unit with nutritious meals, but also operates a staff canteen and provides catering services when required.

Outcome 1.4: Safe and Appropriate Environment

The environment at the hospital is maintained well. There are procedures for the management of waste and hazardous substances and staff members follow these. There are sufficient supplies of protective equipment. Cleaning products are provided by a reputable supplier and monitored for effectiveness.

There is a current building warrant of fitness. Annual electrical safety checks of both clinical and non clinical equipment are completed. There are monitoring processes for other building systems including hot water temperature in rooms used by patients and in the maternity unit, emergency signage and lighting, fire evacuation practices and fire suppression equipment.

There are sufficient bathrooms and toilets to meet patients' needs and additional facilities for staff and visitors. Rooms are spacious and allow for movement and mobility. There is adequate heating, ventilation and natural light.

The organisation has appropriate emergency, essential and security systems in place. There are alternative power and cooking sources in the event of an emergency.

Outcome 2: Restraint Minimisation and Safe Practice

The organisation has appropriate policies and procedures to guide staff in the use of restraints and enablers should these be assessed as necessary. At the time of the audit there are no restraints in use in the facility.

One person is using an enabler (bedrails) to aid mobility while they are in bed. Their file is reviewed and all documentation is consistent with the organisation's processes for the use of enablers. This includes an assessment of need, consent by the resident and/or whanau, monitoring when in use because of the type of enabler, and reassessment due to the short term nature of the need.

Outcome 3: Infection Prevention and Control

The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to patients, staff and visitors. Policies and procedures are aligned with current accepted good practice. There are adequate resources to allow for a managed environment, which minimises the risk of infection. The programme is relevant to the size and scope of services provided and is monitored by the facility's clinical nurse manager who has the role of infection control co-ordinator. Antimicrobial practice for all three services (medical, long term care and maternity) are monitored. Monthly surveillance data is recorded, collated and reported to management and staff. Analysis and evaluation of data is used for quality improvements, which are monitored in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA

Evidence:

Clinical and non-clinical staff interviewed demonstrate knowledge and understanding of consumer rights, obligations and how to incorporate them as part of their everyday practice. Orientation of new staff includes training on consumer rights and obligations. As observed, staff are seen to be addressing patients with respect, knocking on doors and asking to enter rooms prior to entering, and providing the patients with choices. Maintaining privacy and confidentiality is also understood clearly by staff.

ARC requirements are met.

Maternity: Clients interviewed (four women and one partner) confirm service providers and/or the lead maternity carers treat them respectfully and fully involve them in decisions about their care (or care of their babies). This is also verified by reviewing the evaluation summaries sighted during the audit.

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:

Policy is in place to guide staff actions to ensure patients` rights are discussed and available to patients and family/whanau. The Code of Health and Disability Services Consumers` Rights (the Code) is displayed throughout the facility (eg, at reception, in the main entrance to the emergency rooms and ward). The three of three whanau members and three of three patients in the ward interviewed report they are provided with information on the Code on admission. Information is provided in the `Ngati Porou Hauora Patients Admission Booklet` provided on admission to this service and in the service agreement sighted for the long term stay patients. The Nationwide Health and Disability Advocacy Services brochure is accessible for patients, staff and family/whanau on the display table in the ward. The patient advocate contact number is clearly documented in the service information booklet.

ARC requirements are met.

Maternity: The Code of Health and Disability Services Consumers` Rights is clearly displayed in the maternity facility in both English and in Maori. Information on the Code is included in the information packs available in each postnatal room. Four of four women interviewed and one partner confirm they have an understanding of the Code and felt their rights had been upheld effectively. The women verified that appropriate information is provided at the first point of contact with the hospital midwifery team leader interviewed and the community lead maternity carer (LMC). Advocacy and support is discussed initially at the first antenatal appointment either in the client`s own home or at the maternity unit.

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 privacy guidelines for hospital aged care were reviewed in May 2014. Guidelines are provided for all services. Legislation requirements are referenced in relation to maintaining privacy and dignity. Sexuality and intimacy, and maintaining independence was documented in the privacy guidelines reviewed in May 2014.

Professional boundaries are clearly defined in the Professional and Personal Boundaries Policy. There are clear definitions of therapeutic boundaries, boundaries for staff and client/patient, service provider/staff/volunteers. Cultural respect and dignity is documented and maintained by staff on admission and is ongoing during care delivery. NPH is committed to providing spirituality and counselling to all staff and clients/patients as required. Kaumatua services are available.

The Family Violence Zero Tolerance Policy is documented and was reviewed in May 2014. Clear definitions for different types of abuse are available. Screening processes for partner abuse and best practice guidelines reviewed are appropriate for all services. Family Violence Intervention co-ordinator responsibilities for the overall services provided are clear to follow through. A flow chart is also available. Reporting systems are in place and education is provided to all staff. The Family Violence Prevention Programme is developed and implemented within the founding principles of the Treaty of Waitangi.

All patients` individual rooms are single rooms. The two patients in the ward and one other patient, and three of three of three ward whanau interviewed, express a high level of satisfaction with the way they are treated by all staff and report that patients' dignity, privacy and independence is promoted at all times and respected. The general practitioner/medical officer interviewed expressed no concerns with abuse, neglect or culturally unsafe practice. Information on the Nationwide Health and Disability Advocacy Services is provided in the service information booklet reviewed and brochures are displayed. Patients' religious affiliations are recorded, along with ethnicity, on the ten of ten patients' records and on the hospital register reviewed. A church service is held on a Monday in the ward and all patients are welcome to attend.

ARC requirements are met.

Maternity: Four of four women and one of one partner interviewed confirm services are responsive to their individual needs, values and beliefs. This is verified in the client evaluation summaries reviewed. Ethnicity is recorded in the hospital register sighted and the maternity services register. Interviews with the clinical midwifery team leader and the cook confirms the service provides food and fluids consistent with cultural needs.

The hospital midwifery team leader and the community lead maternity carer confirm they have attended training on family abuse, neglect and violence screening to meet the requirements of the Midwifery Council New Zealand. The midwifery team leader, registered nurses and enrolled nurses who cover the inpatient maternity unit are fully trained and any challenging incidents and/or episodes of aggression is reported, investigated and discussed at the staff meetings. The NZ Police are summoned if and when required.

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:

A comprehensive Maori Health Plan is available for review. Background information about the organisation is documented and includes the vision, mission, plans for the organisation, values and strategic objectives to meet. The Treaty of Waitangi is respected and acknowledged. The significance of whanau is documented and accessibility for Maori, as this is predominantly a Maori Health Service. The service does promote equal access to services for all people in this community. The Maori health model adopted by the organisation recognises the importance of understanding and recognising Maori beliefs and values and the significance to Maori. There is acknowledgement by staff interviewed, both clinical and non-clinical, that Maori have special beliefs, skills and knowledge about health, inclusive of: Taha hinengaro – mental wellbeing, Taha tinana – physical wellbeing, Taha wairua – spiritual wellbeing and Taha whanau – family wellbeing. The two patients reviewed are proud of providing relevant iwi information which is documented on the individual patient`s records sighted. There is a kaumatua for Maori patients available. The two of two long term care patients at interview reported their individual religious beliefs are acknowledged and a church service is provided every Monday in the ward lounge. Whanau are encouraged to visit and to be involved in the care planning process with consent of the patient

ARC requirements are met.

Maternity: The midwife team leader and the LMC interviewed participate in ongoing education and training in cultural safety and practices. Both midwives identify as Maori. The Code is displayed in both English and Maori. Cultural safety policies and procedures are developed and implemented for this service. Whenua are stored appropriately while in this facility. Care is individualised and takes into account individual cultural values and beliefs. Hospital and community visit protocols are based on Tikanga guidelines and include concepts such as “Tapu” and “Noa”.

The hospital is Baby Friendly Hospital Initiative (BFHI) accredited and was surveyed two weeks prior to the audit and are awaiting the outcome. Breastfeeding is always encouraged and all staff employed receive and meet the training requirements as explained by the maternity team leader.

The one midwife in the community works in close partnership with the midwife team leader and barriers to access within the organisation are identified and eliminated. Women are able to select a support person of their choice to stay with them in labour, at the birth and during the postnatal period. The support person is established antenatally if possible or when the birth plan is established at approximately thirty six weeks gestation. Whanau are welcome to visit.

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 Cultural Care Policy and the Kaupapa Cultural Safe Care policies are reviewed. The service commitment is documented and how this is to achieved is clearly documented in the policies. Ngati Porou Hauora Charitable Trust is a Maori Health provider with an overarching respect for all cultures and has an understanding that they are based and work in the Maori area of Ngati Porou tribe. The Kaupapa Cultural Safe Care Policy states that the service is committed to the provision of privacy, dignity and respect for each individual resident and patient while ensuring that the Mana of Ngati Porou is always maintained. How this is to be achieved is clearly documented in the policy reviewed. Values and beliefs are respected and information is gained during the admission process for all services. Kaumatua services are available.

Cultural values and beliefs identified during the admission process are documented on the three long term care and three medical individual patients' records reviewed. The admission to discharge planners (for acute admissions and medical patients) and the long term care plans for the (LTC) patients reviewed demonstrate the individual`s culture, values and beliefs are considered and that these rights are effectively met. Staff interviewed support relationships between patients, their family/whanau and the community.

ARC requirements are met.

Maternity: The staff midwife team leader and the community LMC at interview respect the women`s individual ethnic, cultural and spiritual beliefs. The individual cultural needs, inclusive of spirituality, are assessed as part of the admission process and care plan development. Four of four women interviewed confirm that services are provided in a manner that takes into account the cultural and individual values and beliefs for themselves and their babies.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

The service has policy and procedures to guide staff to ensure patients are free of any discrimination, coercion, harassment, sexual, financial of other exploitation. Interviews with four of the five managers and medical and nursing staff evidences staff are fully informed and aware of professional boundaries. All registered nursing staff have to complete a professional boundaries workshop to meet the New Zealand Nursing Council requirements. The educator interviewed stated that most staff have completed the requirements. The organisation has house rules and staff interviewed (clinical and non-clinical) ensure they abide by these rules as part of the employment agreement and human resources management protocol.

Maternity: The midwife team leader and the community LMC at interview report that they receive feedback from women (client evaluation survey summaries) confirming that service providers behave in a professional manner and do not behave in a manner which is detrimental to the well-being of the woman, her baby and partner.

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:

Patients receive services of an appropriate standard based on current good practice. There is a communication diary which is updated with patients` appointments, activities, staff messages and roster changes to alert staff. Outcomes of audits are fed back to staff at the staff meetings (minutes available and sighted). Another example of good practice is the infection control and laboratory results being monitored closely by nursing staff and available for the doctors` rounds. The GP/medical officer commented on the expertise of the senior registered nurses and the midwives and that communication is excellent. The multidisciplinary approach to service delivery is observed during the audit inclusive of management, community teams, radiology staff, the hospital receptionist, ambulance officer, clinical and non-clinical staff.

The medical officer interviewed is fully trained in 'Prime' and resuscitation for neonates, infants, children and adult occurs annually to enable the medical staff to assist professionally in all hospital emergencies, inclusive of maternity emergencies, should they occur. The handover record sheet used between all shifts for nursing staff is beneficial and works effectively to ensure all patients` needs are able to be met, especially as this service is on acute admitting twenty four hours a day, seven days a week.

Several health projects have been instigated and participation by the service was explained by the quality manager. These projects have occurred since the last audit. The service is preparing for Cornerstone Accreditation for the clinics at the hospital and those clinics established within the region. Also the implementation of the Saphere Strategic Development Plan and the implementation of the Clinical Governance Group. The Uawa Clinic has been relocated and the implementation of standing orders for the services provided.

ARC requirements are met.

Maternity: The excellent communication and partnership to service delivery is visible between the maternity team leader and the community lead maternity carer midwife. In one year they have achieved together an outstanding increase in the` numbers of births` at this community hospital and have re-gained the` respect of the community`.

The maternity service has been involved in the Midland Region Rural Maternity Services Consumer Consultation Research Project. The final draft report is currently out for consultation and this is available and sighted. The key themes include access to services, quality of clinical care, information and the role of partners, family/whanau and culture.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The Open Disclosure Policy is available for review. Procedures and general guidelines are clearly documented in regard to open disclosure for errors, adverse events and how to manage such situations. The guidelines include staff responsibilities in relation to open disclosure, what open disclosure should include, for example a sincere apology from the service provider, acknowledgement of the incident, providing contact details and information about the local Health and Disability Consumer Advocate in the region as well as the options for making a complaint, who should be involved, where and how the open disclosure takes place and references and legislative requirements to be met.

The Interpreter Policy is sighted. Interpreters are available locally in the community and at Te Puia Springs Hospital as required or alternatively through Gisborne Hospital Tairawhiti District Health Board. Kaumatua services are available.

The staff communication book in the ward is available and reviewed. The handover record sheet utilised by staff are used appropriately and are beneficial due to the nature of services provided and the hospital staff being prepared to manage acute admissions twenty four hours a day seven days a week as needed. There are private places for meetings and discussions to take place. Each patient has their own individual room.

ARC requirements are met.

Maternity: The nursing staff interviewed in the ward, the midwifery team leader and the community LMC are fully aware of open disclosure and providing accurate and appropriate information ensuring the rights of the women are met. The women have their own individual rooms. Interviews with four of four women and one partner confirm the staff, the midwife team leader and the independent lead maternity carer take the time to discuss their care in enough detail and answer any queries or concerns they may have. Pamphlets and resources are available in the maternity unit for additional information if 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:

The Informed Consent and Consent Policy reviewed has clear definitions of informed consent processes, scope and purpose of the policies. All legislative requirements are documented in relation to informed consent and meet the obligation of the Code of Rights. There are two resuscitation forms available for review. One is the 'Medically Indicated NOT for Resuscitation form' and the other sighted is the 'Patient Initiated NOT for Resuscitation form' Advanced Directive (Guidance from a medical practitioner is required). Policy is documented for children and adults not neonates.

A generalised consent form inclusive of receiving, recording and providing relevant information is utilised for all patients. These are signed and dated in the three medical and three long term care patient records reviewed. If transportation is required for a long term care patient this consent is documented in the residential care service agreement (sighted) signed off and dated. The six of six care plans (three medical and three LTC) reviewed are developed and implemented. There is evidence of informed choices and informed decisions being made by the patients with whanau input if required. The clinical medical records evidence updated plans of action by the medical officers for the acute admissions and medical patients.

ARC requirements are met.

Maternity: The Cultural Safety Competencies include the tikanga in relation to birth, the cultural needs and spiritual needs of turora, the education and orientation of all staff, incorporating an understanding of Tikanga, Te Reo Maori and Whanaungatanga and awareness of the legal issues contained in the Coroners Act. This pertains to the maternity services provided at Te Puia. All babies are for resuscitation.

Systems are in place to ensure women, and where appropriate their family/whanau, are being provided with appropriate information to assist them to make informed choices and give informed consent. The care plans reviewed for different stages of the pregnancy, labour and the birth reviewed are developed in partnership with the LMCs. Choices for care in labour, the birth and the postnatal period are respected and acted upon. Staff at interview demonstrate a good understanding in relation to informed consent processes. The four of four women interviewed confirm they have been made aware of and understand the informed consent process and that appropriate information has been provided.

Routine procedures, such as the Guthrie test or Anti D immunoglobulin administration, requires signed consent. For the administration of Vitamin K after the birth of the baby consent is a requirement. The use of infant formula or nipple shields requires written consent as per the BFHI protocol. Written consent is visible in the four of four client records reviewed.

The two midwives interviewed confirm they each receive on-going information and education about informed consent and this occurs during the technical skills study days which are compulsory for all midwives to attend every three years. The technical skills study days from 2014 have been replaced with the midwifery practice study days (to be attended once every three years) and mandatory emergency midwifery updates (annually) which is inclusive of obstetric emergencies, neo-natal resuscitation and adult cardio-pulmonary resuscitation.

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:

The Ngati Porou Hauora Complaints Policy and process advises the availability of independent advocacy services or support persons of their choice and how to access these. This advice is also given during all stages of complaint resolution. Policy identifies that advocacy services are an essential provision allowing patients appropriate access to independent advice and support. In accordance with the cultural responsiveness policies, all patients receiving services are ensured of prompt access to a culturally and spiritually appropriate advocate if and when required. Advocacy information is available in the Ngati Porou Hauora information booklet provided on admission to all services. Advocacy pamphlets and information is displayed around the hospital and ward. The contact numbers for the Nationwide Health and Disability Advocacy Service are on the reverse of the Code brochure.

ARC requirements are met.

Maternity: Information about the Code and the Nationwide Health and Disability Advocacy Service extends into the maternity unit. Interviews with the midwife team leader and the community LMC and ward staff confirms that the information is explained to women when they are admitted to this service antenatally or postnatally. Information about the New Zealand College of Midwives (NZCOM) advocacy service is included in information provided. Staff are educated to recognise the right to have an advocate/support person present and how to address situations where an advocate/support person is not possible or appropriate.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)
Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)
Consumers are able to maintain links with their family/whānau and their community.

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

Attainment and Risk: FA

Evidence:

The service has policy and procedures to be followed to facilitate the presence of advocates/support persons and these have been reviewed. Visitors/family/whanau policy available for each service provided. Patients are encouraged and supported to maintain links with family/whanau and community services. There is no set visiting. The three of three whanau interviewed confirm unrestricted visiting hours and this is appreciated. Patients in LTC are supported and encouraged to go on outings in the community as part of the planned activities programme or visits to family/whanau can be arranged.

ARC requirements are met.

Maternity: Systems are in place for women to access specialist services antenatally at Gisborne Hospital Maternity Services if and when required and also paediatric services for babies if needed. The remote geographical location and transportation issues make it difficult for women to access additional community services such as lactation consultants or La Leche League. The two midwives available provide additional time and length of stay with women when and if breastfeeding issues arise or to meet any other identified needs.

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The complaints register is maintained by the quality coordinator (QC). Each manager of the area where a complaint is lodged will manage the complaint when it is received. The QC's role is to monitor complaints and ensure that they are managed according to the timeframes of the Code, to collate complaint data and report this (as required by the quality plan) to the organisation – refer Standard 1.2.3.

The complaint register is current and reflects the dates and actions taken. With the organisation's move to using Google Docs, the complaint register is in this system. This allows for electronic links from the register to the complaint summary form which includes the date the complaint is received and the timeframes of the Code, with the steps taken at each point (ie, acknowledgement within five working days, follow up within 10 days). A sampling of four complaints lodged in 2014 is reviewed with the QC and confirms that the process is followed across the organisation. Complaint response letters, and interactions with complainants, are appropriate and respectful.

Within the register there are also two complaints in 2014 which involve one complaint made to the Health and Disability Commission (HDC) and one to the local Nationwide Health and Disability Advocate. In both cases the complaints were found not to be substantiated. An ongoing complaint made to HDC in 2012 was resolved in August 2014.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Ngati Pourou Hauora is governed by Te Runanganui O Ngati Porou. There is a strategic plan, and currently a recovery plan known as Tai ora 1. The chief executive (CE) reports monthly to the board of Te Runanganui against the Tai Ora 1 and the strategic plan. The strategic plan includes key deliverables of the contracts with the Tairawhiti District Hospital (TDH) and other funders.

The CE and her direct reports – the hospital manager (HM) and primary health services manager (PHM) – are interviewed during the onsite audit. (The clinical director is not on duty during the days of the audit and so is not able to be interviewed.) They describe the reporting and management structure which includes weekly meetings in which they discuss, and report on, the organisation's risk register and the projects and key deliverables they are responsible for. The CE incorporates their reports into her monthly reports.

The CE's monthly reports are reviewed. These include reporting of high level risks (see also standard 1.2.3), project performance, financial performance and achievement of organisation's strategic goals and various contractual reviews. The hospital provides a wide range of services to Ngati Porou iwi and people on the East Coast, in addition to those covered by this certification, and there are other associated reviews and audits. Some of these are the Baby Friendly Hospital initiative, the long term review of East Coast services by Saphere Group on behalf of TDH, NPH and Te Runanganui o Ngati Porou, certification to the Home and Community Support sector standards, audit of the Whanau Ora programme by Healthshare, audit of Coldchain process by Ministry of Health, and coming up in October Cornerstone certification of the primary health clinics.

The HM is an experienced manager in the public service at middle and senior management levels. She also has experience as a Nationwide Health and Disability Advocate and has worked for the Police as a Safer Communities coordinator before moving to NPH in mid-2014. She reports that the the PHM (who manages the seven primary health clinics on the East coast out of Te Puia Springs Hospital) and who has previously worked at NPH, is supporting her in her role, as is the CE. During a range of interviews she demonstrates a good understanding of the scope of her role as hospital manager, the responsibilities, and systems at NPH. The clinical director is responsible for the clinical service delivery of the hospital and is one of four doctors employed at NPH. The clinical director is an overseas trained registered medical practitioner who has worked in New Zealand since 2009. He has experience in general practice, general surgery, medicine, acute care, obstetrics, acquired brain injury treatment and rehabilitation and has worked at a large district health board hospital in New Zealand before moving to Te Puia Springs.

ARC requirements are met.

Maternity: The maternity team leader is an experienced registered midwife who has returned to work in this service one year ago. The midwife previously was the longest standing midwife in this region 2000 to 2011. The midwife moved from this region but continued to practice as a core midwife in a primary maternity care setting until here return in July 2013 originally as a locum midwife and has been a permanent midwife since December 2013. The maternity team leader works in partnership with the only community lead maternity carer midwife. This partnership is working effectively for the women in this region and between both midwives they have increased the number of birth from 2013 – 19 births to 41 births already for this year. The maternity team leader is fully aware of the responsibilities and obligations working for this organisation managing the maternity service. Presently the maternity team leader is covering this service twenty four hours a day, seven days a week. With both midwives becoming the second person (back up for each midwives individual practice) when required, the service is very adequately covered by experienced midwives at all times. Staff from the ward cover when a client stays in the unit after the birth of her baby. The maternity team leader reports to management on a regular basis.

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 HM and PHM both work out of Te Puia Springs hospital and are able to provide cover for one another in a temporary absence of one or other. The clinical director is one of four doctors at the hospital. They are able to cover for one another in a temporary absence and times of planned leave. One of the other four doctors is an experienced doctor who has worked for NPH for some years, and is very capable and able to take over the clinical director's duties in a temporary absence.

The CE's monthly reports to the board also record succession planning for other roles within NPH to ensure safe delivery of services at all times.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a well described and documented quality and risk management system which reflects continuous quality improvement principles. Quality and risk management principles are included in the orientation programme and staff members interviewed (10 staff and 4 managers) are able to discuss these principles, and their responsibilities for quality and risk management appropriate to their roles.

Policies and procedures are developed by those staff members whose roles are appropriate to the subject. For example, the maternity policies and procedures which have been the subject of areas for improvement are now all current and up to date. They have been developed by the full time employed midwife with input from local LMC and QC to ensure the documents are in the appropriate format and layout and meet the standard for documents at NPH. Currently all documents are reviewed at least every two years, or more frequency if needed.

The Google Docs electronic system is used to very good effect at NPH for their document management and control. This system is reviewed with the QC during the audit. All documents sighted are current. All staff have access to current documents. Documents which are under review have restricted access to those staff with relevant knowledge to be involved in the review. The QC monitors the progress of the review and ensures it occurs in a timely way.

The quality plan includes the monitoring of service delivery through event reporting – incidents, accidents, complaints, compliments, medication errors, infections and restraint and enabler use – and through a comprehensive range of internal audit tools. There is an annual audit plan which sets out the audits to be completed each month across the year and by whom. The QC monitors their completion during the year and reports on the results to the Continuous Quality Improvement (CQI) Committee until early 2014, and since February 2014 to the Clinical Governance Group.

Every quarter the QC also conducts a CQI report which reflects on progress against the quality plan and also summary events data. In the June 2014 CQI report the event data summary trends show a decline in the number of events, complaints remaining at about the same level of one to two per month across the hospital and seven clinics, but complaint resolution is quicker. A review of medication errors in late 2013 and early 2014 lead to a change in pharmacy and the relationship with this new pharmacy is now being managed and medication errors closely monitored.

This June 2014 quarterly report also reflects an evaluation of the change from the CQI committee which had been functioning well to the Clinical Governance Group (CGG). This was a recommendation by the external review organisation Saphere and the Tai Ora recovery plan. The QC reports that the CGG has been a very positive initiative. It is well supported by the management team and focuses on improvement and is well attended. A complimentary group – clinical advisory group – will take over the operational functions of the CQI committee and work with the CGG to ensure that all its functions are covered between both groups and the CGG can focus on providing clinical leadership to the organisation.

At interview with staff members (10) they report that they receive feedback when they report incidents. Information about collated data is provided through the CQI committee in the past, and the CGG, the Health and Safety Committee and as needed across the different teams. (Managers - 4 - discuss quality improvement data and trends during interviews.)

Corrective action plans are developed on the incident/accident report form in response to an individual event. Each complaint has a complaint summary form which includes the response and action to each individual complaint. Where trends are identified in collated data, the QC develops a corrective action which is recorded on his corrective action register which he then monitors.

The hospital manager maintains the risk register for NPH. This includes risks to the organisation in categories including service delivery, staff satisfaction, contracts. As with the close monitoring of the strategic plan and Tai ora recovery plan, there is currently close monitoring of the risk register. The HM reports against the risk register at her

weekly meetings with the CE. At interview she states that was necessary when the recovery plan was first in plan but they are now looking to review the frequency with which they are reviewing the register and to reduce the frequency.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Incident/accident reporting system is documented for use in all service areas which includes a policy on open disclosure. Incident reporting procedures are linked to the NPH health and safety policies and quality improvement and risk systems. Legislative requirements are documented and referenced accordingly for each policy.

All exceptions to service delivery are reported and recorded using either the incident/accident report form or the complaint form. The incident/accident reporting form is used by staff members to report any type of unexpected event and to record the initial response taken and the immediate corrective action in response to the event.

A review of the incident/accident register maintained by the QC shows that these are completed by the initial reporter and by the manager of the reporter. All required follow-up action is taken in response to the events and this is monitored by the QC. The most common type of event which occurs at NPH is falls by people in the hospital and an additional register is maintained on the ward which records these events and the notification to whanau/next of kin (see also standard 1.1.9), as well as the management strategies post fall events. All four staff members interviewed report receiving feedback when they report events.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Recruitment is conducted by the HM and hospital administrator. Those new staff who hold a professional qualification have this validated at appointment. Health professionals have their evidence of their professional registration and annual practising certificates maintained on their personnel files and this is verified through a review of 12 personnel files. Six of the 12 are for health professionals and all six have a current practising certificate on their file.

The 12 files reviewed demonstrate evidence of a safe process of recruitment, selection and appointment of staff members which followed the organisation's process at the time of the staff member's appointment. It is noted that the files sampled include long serving staff members whose files reflect different processes than are now practiced but were appropriate at the time of appointment.

All staff have a current performance appraisal, or performance agreement for the year ahead if they have not yet been employed for 12 months. The nurses (registered and enrolled nurses) performance appraisal process includes nursing competencies and there is support from the education coordinator (EC) to assist nurses with the attaining the professional development and recognition programme (PDRP) requirements. Of the six health professionals whose files are reviewed five are nurses. Of these two are enrolled nurses (ENs) and both have transitioned to the new scope of practice in 2011 (sighted confirmation from New Zealand Nursing Council) and one of the registered nurses (RNs) has had competency assessed also (January 2014).

There is a well described programme of ongoing training and development for all employees at NPH. This includes the provision of mandatory training and development. There are seven caregivers on staff and all have completed the Careerforce Level 3 Core Competencies certificate in 2010, all have a current first aid certificates. The RNs (five) have current CPR, IV therapy, maternity orientation, neonatal resuscitation, medication competencies and INR training.

All staff (caregivers, RNs, and ENs) have had current training in the organisation's restraint policies, Crisis Prevention Intervention or de-escalation training, infection control, the Code of Rights, fire and evacuation procedures, moving and handling and Treaty of Waitangi/Cultural training. Training records (rather than review of personnel files) demonstrates that three of the five RNs and three of three ENs have completed their portfolio requirements.

Other staff members (eg, in the cleaning services team, kitchen services) undertake development as it is available. For example, the second cook is currently taking part in a programme which covers food hygiene, traditional kai and health eating principals with a dietitian from Tairawhiti District Hospital (TDH). This is complimented by self-directed learning as well as off-site learning. The first cook attended this programme two years ago and reports finding this very useful.

ARC requirements are met.

Maternity: The maternity team leader is solely employed to manage this service. The maternity team leader is a registered midwife who has a valid annual practising certificate. A copy of this APC is available and a copy is retained by human resource management in the individual record reviewed. The midwife is responsible for ensuring the requirements for the New Zealand Midwifery Council are met with all clinical, elective and professional development educational requirements being met for competency requirements every three years. An external review occurs every two years. The midwife maintains her own port-folio. Emergency training is provided at TDHB for both adult and neo-natal resuscitation and this has to be undertaken annually. A midwifery practice day has to be attended from 2014 once every three years. The midwife has an access agreement at Gisborne Hospital (TDHB). The community midwife lead maternity carer has both an access agreement with this facility and one with Gisborne Hospital maternity services. The community midwife has an annual practising certificate and this is verified annually to enable the midwife to practice at this facility and this is an obligation of the access agreement. Family violence education is compulsory every three years and both midwives have completed this training.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)
Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)
The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)
New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The roster is prepared for a month in advance. There is a RN on duty, on every shift, and often an EN as well as a RN. On the days of the audit (morning and afternoon) there are three staff on the ward – one RN and two caregivers. On other days of the roster the three staff maybe a RN, an EN and a caregiver. On the nights there are two staff – one RN and one caregiver.

On the two days of the audit the RNs are working 12 hour shifts because one of the five RNs is on leave. When this happens the RNs work two 12 hour day shifts, two 12 hour night shifts followed by either three or four days off. The RN interviewed reports that this is manageable because everyone works together and 'does a bit more'.

There is a mobile surgical services bus which operates on the East Coast one day a month. Staff from NPH assist on the bus when it is based at Te Puia Springs. The roster shows that on Monday 25th August three staff members (one RN, one EN and one caregiver) were working on the bus that day.

The ARC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The document control policy identifies how health information meets legislative requirements and relevant professional and sector standards. The six of six (three medical and three LTC) patient records reviewed show they are legible and evidence the date, time, name and designation of the provider entering the information. It is noted that patients in the ward have progress notes documented each shift. All patient records are fully integrated. Information details such as address, name, date of birth, age, date of admission and the National Health Index (NHI) number for each individual patient is recorded on the label used on each page of the records sighted. Patient`s preferred names are documented and used. The records are stored in a chart/record trolley in the nurses` station. A signature list is obtained and is recorded in each individual patient record and on the 8 or 16 day medication records. Legislative and health data information maintained meets the NZHIS 8153:2002 Standard.

Patient`s individual additional records or completed forms are stored appropriately in envelopes under the trolley so that they are accessible if needed. Archived records are stored appropriately and are able to be retrieved if necessary.

Clinical staff interviewed including the medical officer ensure confidentiality is maintained. The nurse station door is key pad access only. Information patient boards are out of sight of the public. The hospital patient register is maintained by the hospital administrator. All admissions and discharges are recorded appropriately.

ARC requirements are met.

Maternity: Women are identified by their National Health Index (NHI) number unique identification. Four of four records sampled evidence specific NHI identification. Women and baby information is accurate and up-to-date and includes personal information about past history, the present details and information about the pregnancy, labour and birth. Mother and baby records are separated but in the same folder. Bright stickers, for example, for antibiotic allergies/sensitivities are used as needed to alert staff. The four of four maternity records reviewed meets the NZHIS requirements.

The midwifery team leader is responsible for ensuring the client register is up-to-date with all relevant information that is required, such as legal and preferred names, date of admission to this service, date of birth, ethnicity, usual residential address, name of LMC, next of kin (names, address and contact details). Information about the birth inclusive of the type of delivery, estimated blood loss, name of the person who delivered the baby and other present is recorded. Baby information is obtained if the client is

transferred to TDHB Gisborne Hospital and/or if the baby is delivered at this facility. The date of birth, date admitted, sex of baby, type of delivery, NHI number (obtained after the birth - a responsibility of the LMC), date of discharge, type of feeding at time of discharge is recorded in the register. Baby details are clearly documented due to the nature of this primary maternity service. All Ministry of Health coding is completed by the hospital receptionist. Records are stored appropriately in the maternity unit in a locked cupboard and can be retrieved as necessary.

Records are stored in a locked filing cabinet and the office door is locked when not in use. The unit is locked with key pad access only at all times for security purposes due to the nature of this service.

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:

Policy identifies entry processes which are communicated to patients, family/whanau and referral agencies. There are different avenues for admission as services are available for acute admissions, medical admissions, respite and long term care placement. Acute admissions are arranged through the general practitioners in the community, emergency services via ambulance from the community to Te Puia Springs Hospital or short and long term care placement which is pre-arranged through the needs assessment and service co-ordination assessors for Tairawhiti District Health Board. A register is maintained for the hospital services for all patients admitted and discharged. Some long term patients are admitted from TDHB Gisborne Hospital directly or from their individual homes in the community. Entry to this service is facilitated in a competent equitable, timely and respectful manner.

Three of three long term care patients` records reviewed have had appropriate NASC assessments prior to admission. The records contain the initial contact information and date of admission, copies of any enduring power of attorney (EPOA) if established, and available. Also background information is recorded and the reason for admission is recorded. There is a comprehensive report with all the support needs being identified and summarised with options for meeting the needs and goals established, plus the outcome of the initial nursing assessment is documented to guide staff, and the patient/resident residential agreement, if possible is verified signed and dated.

The three of three medical patient`s records reviewed contain ambulance transport reports, details of admission into the ward and/or the emergency room, vital signs and observations are recorded, investigations pursued for example, laboratory reports, radiology reports and admission details and patient and next of kin information is established in case family/whanau are needed to be contacted. Medical and nursing progress notes are clearly documented and entries are dated and signed at regular intervals and assessments occurring.

Four of four family/whanau and three patients interviewed confirm their input into the admission process.

ARC requirements are met.

Maternity: The maternity service provides home visits or clinic appointments for antenatal care provision. Admissions are by arrangement and/or women in labour who are accompanied by their LMC or those women who may on some occasions turn up un-booked with the service or unannounced in labour. For women who are booked all relevant details are already documented clearly on the individual patient records. Relevant details and the maternity team leader would be contacted if a woman arrives unexpectedly. Back up of the lead maternity carer in the community is available if and when required. Ward staff interviewed are trained to deal with these situations.

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:

Policy describes processes undertaken should entry be declined. This rarely occurs as this an acute service providing twenty four hour seven days a week services for this region. For patients requiring long term care who have not been assessed by the NASC service a referral would be arranged by the medical officer. If an emergency or medical patient is needing transfer to TDHB Gisborne transfer services are arranged immediately and escorts arranged if required to accompany the patient. Ambulance or air ambulance services are available due to the remote geographical location of Te Puia Springs Hospital. The hospital register is maintained by the hospital administrator. Family/whanau would be contacted as reported by staff interviewed.

Maternity: Patients are never declined but appropriate services are arranged by the maternity team leader and or the community lead maternity carer. Depending on the circumstances and any history obtained decisions would be made to either deliver the patient at Te Puia Springs hospital or at Gisborne hospital. If time is not permitting assistance can be summoned from hospital staff and the medical officer on call if required.

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:

Systems are implemented that evidence each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with patients and/or family/whanau input. Care is provided within stated timeframes and is co-ordinated to promote service continuity and team work by staff where applicable. Handover was observed between the shifts. The staff use a handover record sheet which highlights patients at high risk of falling, observations required, new medications commenced and side effects and/or any special instructions to be addressed. Staff training records detail appropriate qualifications and/or experience of staff interviewed. The healthcare assistants are able to perform and assist with expected tasks. Patients and whanau interviews confirm the patients and their family/whanau input into their care planning and access to a typical range of life experiences and choices.

The medical officer interviewed confirms the medical staff (four doctors cover this service and the after-hours) ensure the medical records are well maintained. The doctor confirms the staff inform any medical issues and concerns in a timely manner. The doctor prescribed treatments are followed by staff and any changes are reported. The resident doctor interviewed has been covering this service for some time and lives in close proximity to the hospital and is available for any hospital emergencies or acute admissions. The medical staff roster is well documented and the contact details and clinics held are updated should assistance of another doctor be required at any time. The doctor interviewed has completed all relevant education and has an annual practising certificate which was sighted. Due to the nature of the services provided the doctors are prepared for any situations and/or emergencies.

Staff training and competencies are clearly documented and records are maintained by the nurse educator. All staff receive orientation/induction and ongoing training. Service provider documentation evidences each stage of service provision is undertaken by suitably qualified and/or service providers who are competent to perform the function. The registered nurses are responsible for the assessments, care planning, care provision, evaluations, review and exiting the service for whatever reason. The job descriptions sighted define the responsibilities of all roles. The practising certificates for all health professionals are reviewed annually and a record is maintained.

Three of three medical patient records reviewed have evidence of admission assessments being undertaken and the admission to discharge planners are completed. Day to day assessments are documented at each point of contact with patients and any changes are updated on the planner. Records are well documented by all staff and are current and up-to-date. A multidisciplinary approach to service delivery is utilised in the best interest of the individual patients.

The three of three long term care records reviewed evidence comprehensive assessments occur on admission to this service. The registered nurse at interview states the NASC assessment is taken into consideration when developing the care plan for each individual patient requiring long term care. Presently the care plans are being reviewed by the registered nurses monthly but these only require review six monthly or more often if there is a change of health status or other significant changes occur.

ARC requirements are met.

Maternity: The maternity team leader interviewed is very experienced to provide continuity of care. The community lead maternity carer provides back-up services for the hospital midwife. Both midwives have current annual practising certificates (sighted). The LMC has a valid access agreement to this facility and both midwives have access agreements for Gisborne Hospital (TDHB) under the Primary Maternity Services Notice 2007 pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 and amendments 2010. Each is responsible for their respective patients during their stay in this maternity unit.

Education is provided onsite and the midwives can also as time permits attend education of their choice in the community and/or at the TDHB maternity services to meet elective and professional development requirements to maintain their annual registration and midwifery scope of practice.

Each woman who is booked to labour and birth at Te Puia Springs maternity unit has a plan developed in partnership with the maternity team leader or the community lead maternity carer. This plan is developed at about thirty six weeks gestation and is a requirement of Section 88. There are also plans for both the woman and the baby for the postnatal period when required. The care plans are documented and observed in the four of four records sighted. All entries are dated, signed and designations are recorded.

Women are managed safely on admission and during service delivery. The four records reviewed evidence safe and timely assessments, plans, evaluations and exit from the service is documented.

Women interviewed (four of four) verified that their input is sought antenatally and their individual wishes are always considered and upheld as much as possible. All patients at interview spoke highly of the care received for themselves, their babies and that the partners and/or support persons were involved in their recovery and care. The maternity progress notes ae updated at each point of contact with the mother or the baby and the care plans updated if required. The staff from the ward assist and support woman who stay in the unit and the maternity team leader or the community LMC visits regularly. The service has Baby Friendly Hospital Initiative (BFHI) status and all staff receive training on breastfeeding support.

Tracer Methodology Medical:

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

.Tracer Methodology Long term Care:

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

Tracer Methodology Maternity:

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:

Assessments are performed by the experienced medical and nursing staff. All resources are available to make effective assessments of the patients. The two emergency rooms are well set up in readiness for an admission at all times. Equipment and resources are checked daily and after use. All emergency equipment required is located in the emergency rooms. Ambulance access is in close proximity to the emergency rooms. Staff in the ward are alerted of incoming patients so as to be prepared or to obtain additional staff if required determined by the circumstances at that time. Full assessments are documented and the admission to discharge planner is commenced. Ongoing

assessments are performed while the patient is in the emergency room and continue as required when admitted to the ward. Three of three records reviewed evidenced well documented assessments and assessment tools being utilised. The records are individualised and integrated records are observed.

For long term patients admitted to this service the NASC comprehensive assessment is used as the basis of the care planning process for the long term care plan. An initial care plan is developed for the first three weeks prior to the long term care plan being developed. Three of three records randomly selected evidenced thorough assessments and the use of recognised tools such as the waterlow pressure area prediction, falls risk, nutritional, mobility, skin integrity, wound and other assessments being utilised. Recreational assessments are also conducted. The needs, outcomes and goals for patients are identified through the assessment process. Patient vital signs are recorded on admission and monthly thereafter. The records are integrated with dividers for each section and easily able to be followed through. An index is in the front of each record reviewed.

ARC requirements are met.

Maternity: The service provider has an assessment room which can be utilised by the lead maternity carers for women at any stage of their pregnancy or for an assessment if in early labour. The assessment room is well equipped with equipment such as a sphygnometer, stethoscope, CTG machine and other resources which may be necessary. Blood specimens can be taken by the LMCs and stored in the laboratory fridge up in the hospital clinic.

The four of four patient records randomly selected are well maintained by the maternity team leader. The mother and baby notes are separate but contained in the one folder. Assessments occur at each point of contact with the women during the antenatal clinic or home visits and records are maintained appropriately. Labour and birth records are required and records sighted are clearly documented. The postnatal period all assistance and support provided is documented for both the mother and the baby. The care plans are updated if required from the assessments made. There are three individual postnatal stay rooms.

Assessment and intervention outcomes are communicated with the individual woman and referrers if required. The midwife discusses each stage of service provision with the women in her care and with consent their respective partners. Explanations are provided should a referral to an obstetrician be required. A clinic is held monthly at this hospital for visiting specialists. The maternity clinic is well set up and privacy is maintained. Women interviewed reported that they well always kept well informed during all stages of service delivery. One woman interviewed had not delivered her baby but assessment continue and a plan is in place that she is to deliver at Gisborne Hospital Maternity Services due to risks identified and this is clearly documented on the individual record reviewed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The six of six records reviewed across the medical and LTC services evidenced service delivery assessments and plans are individualised, accurate and up-to-date. Identified needs are documented with interventions to meet desired outcomes for all patients. Short term and long term care plans are documented. Any risks identified are clearly documented to alert staff.

Patients and family/whanau input into the service delivery plans indicates a satisfactory level of communication with the patient`s and/or whanau. Clinical nursing and medical staff confirm that the service delivery and medical plans are effectively documented for these services. The records are integrated and there is evidence of multidisciplinary staff input and continuity of service delivery. Dividers are between each section. Records are accessible in the ward and old records are available.

ARC requirements are met.

Maternity: The individual records reviewed are individualised and mother and baby focused, integrated and continuity of care is promoted for both the woman and the baby. Three of four records reviewed also include the parenting and mother craft goals as well as rest and recovery from the labour and the birth. Other educational needs are addressed, for example breastfeeding, 'skin to skin', safe sleeping, baby cares, bathing and settling baby/pepi. Pamphlets and booklets are readily available in the maternity unit on all relevant topics. There is evidence of family/whanau involvement in the maternity notes reviewed. The one other record reviewed is antenatal which has the labour and birth plan clearly documented. Previous or known risks are documented to alert the LMCs and staff covering the unit as 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 three of three medical and three of three long term care patients` records reviewed identify assessments are completed, identified needs are documented and action plans and/or interventions in the LTC plans provide actions on how the goals set can be achieved. The care plans are updated daily for the medical patients and presently monthly for the long term care patients. This will be revised to six monthly and more often only if required. The long term care patients have input into their own care plan. The patients interviewed confirm current care and treatments meets their needs. The four family/whanau interviews confirm staff are respectful, courteous and a high standard of care is maintained. The progress notes both medical and nursing record liaison and consultation. The ward staff utilise a communication book (sighted) which is read by staff each shift.

ARC requirements are met.

Maternity: In the four of four records reviewed there is evidence of the interventions relating to the patients` assessed needs and set goals to achieve if possible in the timeframe provided or ongoing in the home if the woman decides to be discharged after the birth of the baby. There is adequate supplies and time to support achieving the set goals. The woman can stay forty eight hours or longer if required. Additional length of stay can be arranged if a woman is having any issues with a medical related problem, or for further breastfeeding advice, care and management. Also geographical location is taken into consideration at time of discharge. The LMCs and the women decide what is in the best interest of the mother and baby at the time of discharge. The women interviewed and one partner interviewed expressed satisfaction with the service received during their stay in this maternity service.

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:

In the medical and long term care ward the staff are presently organising the activities programme which is developed and implemented. The programme is displayed in the ward and in the nurses' station. The activities are planned to develop and maintain patients` independence, strengths and reflect ordinary patterns of life. Family/whanau are welcome to participate and support the patient. The programme reviewed is varied and interesting and some activities involve community groups visiting and some outings for the patients into the community or home visits with whanau if able. A group of women from a nearby town visit weekly and spend the morning with the patients in the lounge. Most patients are whanau. The patients are seen to be playing card games, listening to music with words on the large screen provided and enjoying the activities provided along with morning tea. School groups visit from the local primary school to sing and dance or walks outside are encouraged on fine days. The LTC patients interviewed verified they enjoyed the activities and they can join in if they wish.

ARC requirements are met.

Maternity: There are no planned activities due to the nature of this service. Needs of women vary and support level required is often ascertained during the assessment process on admission. Partners are involved as much as possible with baby cares. The time in the unit is maximised with activities that would be meaningful. Parenting skills are advocated and encouraged by staff. There are several goals to endeavour to achieve in the timeframe provided which will increase the skills of the mother and her partner, especially for first time parents.

Staff and the LMCs provide full support with breastfeeding as required to ensure the woman has a good technique and positioning when breastfeeding the baby. Settling and wrapping baby and teaching about safe sleep 'back is best' positioning. Multiparous women often need a refresher, rest and reassurance managing a new-born baby again. Encouragement and support is promoted by staff until the woman`s confidence returns.

Discussions with the two LMCs often ascertains which activities will be of the most benefit to the woman in the time provided.

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:

Progress records are evaluated each shift and at each point of contact with the patients in this medical and long term care setting. The medical patients care plans are reviewed daily on the admission to discharge planner and care plan. Each entry is dated and signed by the staff member making the entry. The long term care plans for the LTC patients are being reviewed monthly but this has been changed to six monthly or more often if required if there are any significant changes in the patient`s condition. The care plans are reviewed by the registered nurses as part of the multidisciplinary review.

ARC requirements are met.

Maternity: Care is evaluated at each point of contact with the woman and the baby. Any achievements are acknowledged in the maternity notes regularly. Each entry sighted is documented, dated and signed with signature and designation of the service provider involved. Partner/family/whanau involvement is documented. The main goal and/or outcome as discussed with the LMCs is to have a healthy mother and a healthy baby.

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:

Patient safety is paramount and the senior registered nurse and medical officer interviewed ae fully aware of their responsibilities in conjunction with a patient requiring a referral or subsequent transfer to secondary care. If a long term patient requested to access another health and disability provider the NASC service would be notified. Assistance would be provided by staff.

Transfers of patients for medical reasons are authorised by the medical officer and each stage of the transfer would be documented. The referral system and processes for secondary care is documented to guide staff. Transportation by ambulance or air ambulance (helicopter) services is arranged appropriately. Two referrals and transfers occurred on the day of the audit. The hospital register was updated. If required an escort is arranged. Copies of any referrals are retained in the communication section of the integrated records reviewed. The service has visiting specialists who visit this facility so that people in the community do not have to travel the long distance to Gisborne Hospital for assessments. A general specialist visits this hospital every Tuesday, ear nose and throat specialist and audiology on Fridays and an obstetrician/gynaecologist every Thursday. The mobile surgical bus visits once a month for minor surgical procedures and oral dentistry services are provided.

ARC requirements are met.

Maternity: Any patients requiring a referral to TDHB Hospital Maternity Services needs to be appropriately referred by the lead maternity carers. If a woman is needing a consultant referral the referral process is followed as per Section 88 and an appointment is arranged at Te Puia Springs Hospital if possible (the obstetric specialist visits once a month). For other assessments or investigations a woman may require an outpatient referral to clinic at Gisborne Hospital Maternity Services. A copy of the referral letter is kept in the individual patient`s record.

Where a baby is requiring a referral to a paediatrician, for an example, the lead maternity carer is responsible for making the referral. In the event of an obstetric emergency a telephone referral is made to Gisborne Maternity Services by the LMC prior to the transfer to ensure the team will be expecting the patient and to have emergency services available. An air transfer may be required in such an emergency. Medical staff at the hospital are fully trained and are on-call to assist in any emergency situation inclusive of obstetric emergencies and support the lead maternity carers as needed. The LMC always accompanies the patient and/or baby if a referral and transfer occurs. Records are maintained.

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:

A transfer and/or discharge from this facility is managed appropriately and each stage is communicated to the patient and/or support person. Policies and procedures for the transition, exit, discharge or transfer of patients is documented and implemented. Six of six patient records sampled demonstrate exit, discharge or transfer planning and that this is communicated to all relevant providers. Any referral, transfer or discharge information in the form of letters are retained in the individual patient records. Risks are monitored and safety is promoted at all times with effective discharge planning. The discharge process and record keeping is appropriate for the services provided.

For the medical admissions discharge commences on admission to this service. The admission to discharge planners reviewed in the three of three individual patient records evidences information is sought and planning is arranged for when the actual discharge occurs. Follow-up appointments, home help or other services are arranged before the patient is discharged to the community.

ARC requirements are met.

Maternity: Transfers are organised if the level of care is not able to be provided in labour for this primary maternity care setting or should there be an obstetric emergency. There is a documented transfer process to guide staff. The LMCs interviewed clearly are aware of their responsibilities. A transfer form is completed by the LMC which contains relevant information. The LMC travels with the patient if an ambulance transfer or other services is required. The records go with the patient if transferred to secondary care. The incidence of these situations is low due to the entry criteria being effectively managed. Should this be required the patient is kept well informed and the partner/family/whanau. Documentation of what has occurred is significant and is recorded accurately by the LMCs and staff involved.

Patients are discharged as per the TDHB agreement for maternity services. An additional length of stay can be arranged if there is a significant issue with breast feeding or for a medical reason. The discharge summary is completed. The discharge is coded for the MOH requirements by the hospital receptionist.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are detailed policies and procedures available for Medication Management and safe systems documented. Processes and guidelines are accessible for staff that comply with current legislation and safe practice guidelines. Policies and procedures are linked to Gisborne Hospital TDHB. The medication policies and procedures have been recently reviewed in 2014. Policies and procedures outline the service provider`s responsibilities in relation to each stage of medicine management. Responsibilities are outlined for the registered nursing staff, pharmacy technicians and the medical staff. There are standard procedures for antibiotics use and controlled medications. There is reference to the aged care safe medication guidelines.

The service has a contracted pharmacy in Gisborne. The service use a blister pack system for the long term care patients and this is working effectively. Any changes to the medications or packs to be made up for new admissions are faxed through to the pharmacist and returned by courier as required. The packs are delivered monthly and these are checked by the pharmacy technicians and by the registered nurses when packs are delivered. There is evidence of three monthly medication reviews occurring for the LTC patients and regular reviews for the medical patients when visited by the doctor on duty. The medical patients medications are charted by the medical officer dated and signed off appropriately. Any discontinued medications are ruled through and signed off by the doctor. There are four doctors who cover this hospital. 'PRN' (as required) medications are monitored by the registered nurses and discussed with the doctor if required. The registered nurses administer the medications for these patients from the medication trolley which is locked when not in use. The lunch time medication round was observed and was managed safely.

There is a medication room with an impress system in place. If any medications are removed to the ward or emergency services this is documented for replacement. Expiry dates are monitored closely by the registered nurses. Any expired medication is returned to the pharmacy. Adequate stocks are available. This room is locked at all times.

The controlled drugs are stored safely and appropriately to meet legislative requirements. Double locked cupboard and in a locked room. Once a week on Fridays two registered nurses or a registered nurse and an enrolled nurse check the controlled drugs and evidence that this occurs is documented in the register sighted.

There is a procedure for reporting incidents related to medicine management. Medication allergies and/or sensitivities are recorded on the patient's file (yellow stickers) and on the medication record. Photograph identification is used on the medication records reviewed. Medication fridges in the ward and the emergency room are monitored daily. Emergency medications are locked in the emergency trolley. The vaccine fridge is monitored daily and the cold chain policy is clearly documented to guide staff. Vaccine is available for Hepatitis B but should Hepatitis B immunoglobulin or Anti D be required a prescription is required and this is subsequently ordered from Gisborne Hospital and sent by courier to this facility under special courier processes (needs to be maintained at a certain temperature when transportation required).

Twenty medication records in total are available for review for all services inclusive of maternity. Staff use the eight day medication records for the medical and maternity services (mother and baby have their own records) and the 16 day medication record for the long term care patients.

The registered nurses complete intravenous certification two yearly and records are maintained by the hospital educator.

There are no patients who are self-medicating medicines. Processes are in place should this situation arise.

The registered nurse interviewed explained that only registered nurses (5) administer the medications. All staff have completed the safe medication administration annual revalidation questionnaire. Competencies are completed and records are maintained.

ARC requirements are met.

Maternity: Medication records for mother and baby were reviewed. Minimal medications are used in this primary maternity service. There is no evidence of controlled medications in the maternity service. The midwife team leader and the community LMC are registered midwives with current annual practising certificates and the midwives are able to prescribe within their scope of practice as per the New Zealand Midwifery Council (NZMC).

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There are five kitchen staff, with two cooks and three kitchen assistants. They work across the week from 7am to 5pm. There is at least one cook and one or two other staff members on Monday to Friday and one cook and one other staff member on Saturday and Sunday.

There is a four week menu with summer and winter variations which is used in a four weekly cycle. This is reviewed by a dietitian from TDH biennially and was most recently reviewed in June 2014. Some substitutions are made to individual menu items based on availability and freshness of ingredients. Where substitutions are made these are recorded so that a record is kept, and this change can be incorporated into the menu in the coming days and weeks. The menus are reviewed and the first cook interviewed during the onsite audit.

There are several people who are having moulied food during the week of the audit visit and this is clearly recorded on the weekly plan, along with each person's breakfast preferences and the time for their breakfast. This includes one person who is having an earlier than usual breakfast due to going to Gisborne for an appointment. One person is diabetic and has appropriate substitutions to the main menu.

The kitchen also produces food for the staff cafeteria and also caters for functions or events held at NPH. The kitchen team are able to incorporate this into their daily schedule due to having good plans and the menus to follow.

The food storage systems are effective and well implemented. In all locations: the four freezers, two refrigerators, two chiller rooms, and pantry are all well organised, have food stored so that it is accessible, and food is dated and easy to find. Food is fresh and of good quality. Freezer and fridge temperatures are monitored daily. Recording sheets note the desired temperature range and what action is to be taken if the temperature is outside the desired range. The temperatures for these appliances over the past months is randomly sampled and is safe through this time.

The day of the interview with the first cook is the day of the weekly food delivery. There is still sufficient food available in the freezers, chillers, fridge and pantry that in an emergency they could manage for a minimum of three days.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are sufficient and available supplies of protective equipment to handle waste and hazardous substances. At interview with the two team leaders of cleaning and maintenance they report that they are able to access training, information and equipment appropriate for the safe management and handling of such substances at the NPH facility.

In the cleaning storeroom there are supplies of protective equipment, aprons, gloves and masks, and are additional supplies on the cleaners' trollies, on the ward and in the maternity unit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a current building warrant of fitness which expires on 12 June 2015. The building is a purpose built hospital and although older is being well maintained and kept clean and in good order.

There are hand rails throughout. The floors are even surfaces and corridors wide and easy to access for people with mobility issues. There are safe external areas which can be accessed from the buildings.

Electrical testing of clinical and non-clinical equipment occurs on a regular schedule. Clinical equipment is tested by a specialist team from TDH and non-clinical equipment by a local electrician. An inventory of electrical equipment is maintained.

ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are sufficient numbers of toilets and showers / bathing facilities which are conveniently located in the ward and maternity area, where people will use them. These are in addition to visitor and staff allocated toilets and showers. All have appropriate signs and privacy locks.

The maternity unit has one bathroom with a toilet and shower which are separate from one another. In the long stay ward (aged care) there is one bathroom with two (separate) toilets and two (separate) showers. There is a second bathroom which can be used as an isolation bathroom when needed, with one (separate) toilet and shower.

There are additional visitors' toilets (for men and women) at the main entrance to the hospital and at a clinic, and staff allocated toilets at two locations within the hospital buildings (for men and women).

Hot water temperatures are monitored by the maintenance team. Records of monitoring are reviewed with the maintenance team leader. The records indicate that temperatures are maintained at 45 degrees and if higher this is addressed immediately. Tempering valves are used at the basins in each room as well as the bathrooms.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Rooms in the long stay (aged care) ward are personalised. As noted, the building is a hospital and the rooms are large, airy and light. The long stay and maternity unit rooms are single rooms, the medical (hospital) ward are four bed rooms. All have ample room for people to move around their room and bed, including those people who use mobility equipment (eg, wheelchairs, walkers).

People can be moved on their beds within the environment if needed as corridors can accommodate the width of a bed and attendants if needed.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

There is a large lounge / dining area at the end of the ward which is used by people for socialising, activities and dining. This room can accommodate all patients at NPH if at full occupancy with ease.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The cleaning team leader is interviewed during the onsite audit. There are protocols for cleaning in each area of NPH and checklist to ensure that the daily cleaning is completed. The team leader reviews the cleaning through a visual check when she is on duty and when she returns to duty from days off. The checklists are used in the seven clinics (which she is also responsible for) as well as the hospital, although she visits each clinic approximately monthly.

The cleaning team leader states that her colleagues will tell her if there are deficiencies in the cleaning practice of her team and that they are 'not shy' in doing so. She is confident that any issues are identified. At interview with the QC he reports that as part of the monitoring of incidents/accidents he will identify any issues with the effectiveness of cleaning and laundry processes.

All laundry is contracted out and done off site.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation provides training at orientation and then biennially on its fire and evacuation procedures. Review of personnel and training records confirms that all staff are current in this training.

There is an approved evacuation scheme for the hospital. This was reviewed again in October 2012 by the Gisborne Fire Department and the plan again approved. The most recent first evacuation practices have been on 3 April and 8 May 2014. These are recorded on the organisation's fire evacuation form.

The hospital facility maintains the water supply for the town and the maintenance team monitors the water quality regularly. The water is in a 225,000 litre tank. There is a backup generator for the hospital with onsite diesel storage tank. The generator will run for up to a week and will operate all the hospital's systems. There is an LPG storage tank which is used for cooking. As there is on site storage rather than reticulated it is not affected if main supplies fail.

There is a call system in the ward and maternity unit. This alerts staff to the room where it is activated. During the audit the call bell is rarely activated but when it is, it is responded to promptly.

There are appropriate security arrangements for NPH. Some rooms are routinely kept locked with limited access by key or keypad. These are the medication room, the resuscitation room and the nurses' station. During daylight hours the hospital is open as there are clinics in the building. However, the ward and maternity are accessed by passing the main entrance, a reception area and the nurses' station. All external doors are locked by 8pm at night and unlocked at approximately 6.30am.

A review of the incident / accident reports and the complaints register shows that there are no issues raised about the security and safety of the building. Similarly during interviews people report feeling secure at NPH.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The building is an older style hospital. All rooms have large, opening windows which allow in natural light. Security latches are attached to windows for safety but allow ventilation. Radiators use the hot water from the thermal springs the town is known for heating and the building is a comfortable temperature throughout the audit visit.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The organisation's policies and procedures emphasise the minimisation of restraint use and that the use of enablers is voluntary. Safety is the main component in the use of any equipment to promote independence. There are clearly described policies, procedures which include the approval of restraints and enablers and the role of the restraint coordinator within the organisation.

At the time of the onsite audit visit there are no restraints in use at NPH and there has been no use since 2013. Enablers are used and these are voluntary.

The one enabler in use at the time of the audit is included in the care plan and assessed needs for the person. There is also a request for the enabler to be used (bed rails) so that they can turn more easily while in bed. The consent is signed on their behalf by the person's next of kin on their admission (23 August 2014). (They are admitted for a short stay at NPH with an infection and high levels of opiate pain medication.)

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The service infection control policies and procedures are available for review. The policies and procedures are linked with the TDHB infection control programme. The quality manager interviewed is currently in communication with the infection prevention and control nurse specialist at Gisborne Hospital in view of setting up a formalised memorandum of understanding for infection control support and advice as required.

The infection control team is documented for the organisation. Clear standards, definitions and organisational guidelines are available to guide staff and have recently been reviewed. The policies are well documented throughout the manual. There is a contact flow chart for infectious diseases. All standards and legislation required to be met is documented. Infection prevention and control (IPC) processes are implemented to minimise risk of infection to patients, staff and visitors. Signage is observed around the ward and on the door of the maternity unit to inform and remind visitors that if they are unwell they should not be visiting patients. Staff interviewed understand about staff illness and when not to come to work and when to return to work.

Sanitising hand gel dispensers, flowing soap and hand towels are observed throughout the ward and there is adequate hand washing facilities for staff, visitors and residents. Staff interviews demonstrate staff have a good understanding and awareness of standard precautions. Patients with consent have been vaccinated for influenza in March and April this year and this is recorded in each individual long term care record reviewed.

The health care assistant (HCA) interviewed has a good understanding of infection prevention and control. The clinical nurse manager is the infection control co-ordinator (ICC) but is absent at the time of the audit. The hospital administrator, the medical officer interviewed and the HCA make up the infection control committee led by the ICC. Evidence of infection control meetings which are held every second Wednesday of the month are well attended and the minutes are readily available. A set agenda is used at the meetings held. The last meetings was documented as the 13 August 2014.

Policies and procedures cover all aspects of IPC relevant to maternity, medical, geriatric and other services provided at Te Puia Hospital. The infection control management is closely linked to health and safety and to the quality and risk management systems as explained by the quality manager interviewed.

ARC requirements are met.

Maternity: The service maternity team leader and the LMC interviewed are clearly very experienced and have a good understanding of infection prevention and control. The service has additional policies and procedures relevant to maternity services. Pregnant women were also provided with the opportunity to have a free vaccination as part of the Ministry of Health Programme. There is adequate personal protective equipment/resources evident in the maternity unit. Hepatitis B status is established as a result of antenatal screening. Precautions are taken if required as per the processes documented and available to guide staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control committee has expertise and resources available to meet the standard requirements. The infection control committee comprises of the Clinical Nurse Manager (ICC), the medical officer, the hospital administrator and one healthcare assistant. The terms of reference are clearly documented on the policy sighted and the role of the (ICC) is clearly defined and for the committee. The infection control programme implemented meets the needs of this organisation and provides adequate human, physical and information resources. The ICC oversees the programme and is responsible for implementing the education programme and the surveillance activities. The ICC though not able to be interviewed is an experienced senior registered nurse, who has attended relevant education for this additional position.

The medical officer, nursing staff and midwives have access to laboratory results of patients. Additional advice can be sought from visiting specialists from TDHB, from pathologists at the laboratory and/or the IC Nurse Specialist at Gisborne Hospital if and when required.

ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The services have comprehensive policies and procedures appropriate for long term care, medical and maternity services. The policies are next to be reviewed in 2016. The policies and procedures reflect current accepted good practice and legislative requirements and cover all requirements of the Health and Disability Services Infection Prevention and Control Standards. There are clear guidelines on how to manage infections and outbreaks, food safety, linen and laundry services.

Education is provided to all staff inclusive of hand washing, standard precautions, transmission based precautions, prevention and management of infection, antibiotic use, outbreak management, disinfection and sterilisation (including reprocessing of reusable medical devices and equipment) and single use items. The organisation has a policy in the case of renovations and any construction taking place.

Observations during the audit identify the implementation of infection prevention and control procedures. Staff demonstrate safe and appropriate infection prevention and control practices.

Maternity: The policies and procedures are accessible online and in the hard copy infection control manual sighted. Cleaning and disinfecting equipment such as the portable birthing pool, electric breast pumps, CTG belts and the return of body tissues (ie, whenua). The delivery packs are disposable. The midwife team leader and the LMC at interview clearly understand the principals of infection control management.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The nurse educator and the clinical nurse manager (ICC) ensure all staff receive adequate and appropriate infection prevention and control education. Both are very experienced registered nurses who have also worked at the TDHB. Attendance records are maintained and all staff have an individual training required. Infection prevention and control education is provided as part of the orientation/induction programme for all newly employed staff and is ongoing.

The service leaders also have a teleconference with the TDHB surgical bus team. This service is newly developed and implemented. Minor surgery and oral procedures are performed mostly. Infection control topics discussed include; 'Your five minutes for hand hygiene', infection control practices, cleaning and drying instruments, personal protective equipment/resources use, safe disposal, isolation and barrier nursing, infection control standard precautions and good communication. Patient education is provided when and if required and recorded in the progress records if this occurs.

Maternity: The midwifery team leader and the LMC interviewed are fully informed and aware of reporting any infection incidences to the ICC. Patient education is paramount in this maternity setting and patients/family/whanau are encouraged to wash their hands before and after handling new-born babies and providing cares to both mother and baby.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

The organisation has a system in place to ensure the infection prevention and control committee has access to expert advice relating to undertaking surveillance of infections to meet the Health and Disability Sector Standard requirements related to the varied services provided. The medical officer interviewed is available for advice and can seek additional advice if required from other health professionals. The contracted pharmacist is also available for consultation.

The ICC is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (eg, hospital / facility acquired infections) are documented to guide staff. There are two forms developed and implemented for the surveillance process. Information is collated on a monthly basis of respiratory, influenza, urinary tract infections, skin and soft tissue, multi-resistant infections (such as MRSA, VRE and ESBL (nil at present)), diarrhoea, eye and noso-cromial infections and other infections if identified. Information gathered is then analysed and reported at the monthly infection control meeting and results are fed back to staff if there are any quality improvements related to infection control practices at the staff meetings. The information is currently sent through to TDHB Gisborne Hospital to the infection control nurse specialist (ICNS) for any feedback if required. The quality manager is in contact with the ICNS to form a relationship and to obtain a memorandum of understanding for infection control at this hospital and in the community. Any notifiable diseases or outbreaks would be reported by the medical officer to the appropriate agency, HealthCERT and the TDHB.

Antimicrobial infections are recorded and antibiotic usage is monitored for the acute and medical patients. This information is clearly documented by the clinical nurse manager ICC reference 3.6 of the Infection Control Standard.

Maternity: The midwifery team leader and the LMC interviewed are aware of their responsibilities in relation to reporting any incidences of infection to the ICC.

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.)*