

# Taslin NZ Limited

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Current Status: 16 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

Taslin NZ Ltd operates Otatara Heights Residential Care & Rehabilitation Home in Taradale Hawke's Bay. The two owner / operators purchased the facility in November 2013. This is their first re-certification audit since that purchase.

Otatara provides rest home level services and residential care for adults under the age of 65 with a physical disability. On the first day of audit 38 residents are supported at Otatara, 22 rest home level care residents and 17 younger people (under 65 years of age) with physical disabilities.

Two low risk areas for improvement are identified. These relate to the lack of documentation of progress towards meeting goals at the six monthly evaluations (which are occurring) and some improvements needed to three of the bathrooms, which have been identified by the new owners.

## Audit Summary as at 16 September 2014

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 16 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.
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### Organisational Management as at 16 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.
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### Continuum of Service Delivery as at 16 September 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 16 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 16 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.
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## Infection Prevention and Control as at 16 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.
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## Audit Results as at 16 September 2014

### Consumer Rights

The service has processes in place that demonstrate their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family/whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whanau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

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

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

Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whanau rights to full and frank information and open disclosure from the staff is demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whanau and the community. Residents have access to visitors of their choice.

There is a complaint process and register which complies with the required standard.

### Organisational Management

Taslin NZ Ltd has a current governance and quality plan which sets out their strategic and quality goals. These are consistent with a facility which provides rest home level care and support to people under age 65 with physical disabilities. There is an appropriate management structure and

plan for any temporary absence of either of the two owner/managers or the care manager, who is experienced at the facility and knows staff and residents well.

The quality and risk management system implemented at Otatara Heights meets the requirements of these Standards. There is reporting of all exceptions to expected service delivery and data is collated and analysed. This information is shared with staff, and when relevant residents, so that any trends are identified and issues can be addressed appropriately. There is calendar of internal audits which monitors all aspects of service delivery at Otatara Heights.

There are effective human resources management systems which guide the recruitment and appointment of staff members, orientation and ongoing training, performance management, leave provisions and other aspects of employee management. There is a comprehensive programme of training, competency assessment and appraisals in place.

Staffing levels are appropriate to the needs of residents and this is confirmed at interview with them and staff members.

Each person has an individual clinical file, which is maintained in a timely manner, held securely and confidentially and includes all necessary information to provide safe care.

### **Continuum of Service Delivery**

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. If residents' needs exceed the care able to be provided at this facility they are reassessed and transferred as required.

The service meets the requirements and timeframes for assessment, care plan development and evaluation of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes. There is an area requiring improvement relating to evaluation of care six monthly, including documenting the resident's response to interventions and progress towards meeting their goals.

Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

The service provides planned activities to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The service has links with community organisations for activities both onsite and offsite.

The observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that are reviewed as being suitable to meet the nutritional needs of the older person. Residents receive additional or modified nutritional requirements, special diets and food that takes into account the resident's likes and dislikes.

## **Safe and Appropriate Environment**

Waste and other hazardous substances are managed appropriately and safely. Staff members have access to supplies of personal protective equipment and there are guidelines for management.

There is a current building warrant of fitness for the facility and building safety checks are maintained. All electrical equipment is checked regularly and hot water temperature in residents' basins and bathrooms is monitored. An area requiring improvement is identified in relation to three of the bathrooms, to ensure that they remain safe for use by all residents.

There are adequate numbers of toilets and showers for residents to use, and there is a separate, and identified staff and visitors' toilet. Personal bedrooms meet residents' requirements for space and accommodate mobility equipment for those people who use it. There are three lounge / dining rooms, which accommodate the needs of the residents on a day-to-day basis and when there are large celebrations.

Cleaning and laundry services are effective and timely. Staff members are rostered to undertake these tasks on a daily basis, throughout the week and the facility is noticeably clean and tidy. Cleanliness is monitored by the care manager through regular internal audits. A recent initiative is cleaning and laundry staff members completing their own daily and weekly checklists so that they also are monitoring their own work.

Essential and emergency systems are in place and have been tested during a recent region-wide power outage. There is an evacuation plan which is regularly practised, emergency food and water supplies on site, fire evacuation training, emergency power and cooking sources. There is a call bell system which, although not used frequently by residents, is responded to by staff when activated.

All rooms have external windows overlooking a garden. Windows open to allow in natural light and ventilation and there is electric heating. Residents report being satisfied with the environment at Otatara Heights.

## **Restraint Minimisation and Safe Practice**

There are systems for the assessment, use and monitoring of restraints at Otatara Heights, however on the days of audit there are no residents using restraints. The organisation has an identified restraint coordinator and is able to utilise these systems, should they be required.

There are three residents who use enabling equipment voluntarily, and all appropriate systems and documentation are in place to support this occurring safely, as required by these Standards.

## **Infection Prevention and Control**

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The

service's policies and procedures comply with relevant legislation and current accepted good practice.

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

There is a monthly collection of surveillance data for infections. The surveillance data is collected, collated and analysed, with results communicated to staff. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. The service has clear procedures to deal with outbreaks.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Taslin NZ Limited
<b>Certificate name:</b>	Taslin NZ Limited
<b>Designated Auditing Agency:</b>	The DAA Group Limited
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	Otatara Heights Residential Care & Rehabilitation Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	<b>Start date:</b> 16 September 2014 <b>End date:</b> 17 September 2014
<b>Proposed changes to current services (if any):</b>	Removal of hospital services from the scope of certification – as requested by the provider
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	39

## Audit Team

<b>Lead Auditor</b>	XXXXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	8
<b>Other Auditors</b>	XXXXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	4

## Sample Totals

Total audit hours on site	24	Total audit hours off site	20	Total audit hours	44
Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	3
Number of residents' records reviewed	10	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed		Total number of staff (headcount)	36	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Friday, 10 October 2014

## Executive Summary of Audit

### General Overview

Taslin NZ Ltd operates Otatara Heights Residential Care & Rehabilitation Home in Taradale Hawke's Bay. The two owner / operators purchased the facility in November 2013. This is their first re-certification audit since that purchase.

Otatara provides rest home level services and residential care for adults under the age of 65 with a physical disability. On the first day of audit 38 residents are supported at Otatara, 22 rest home level care residents and 17 younger people (under 65 years of age) with physical disabilities.

Two low risk areas for improvement are identified. These relate to the lack of documentation of progress towards meeting goals at the six monthly evaluations (which are occurring) and some improvements needed to three of the bathrooms, which have been identified by the new owners.

### Outcome 1.1: Consumer Rights

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

Resident and family/whānau interviewed confirm their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each resident's independence and reflects the residents' and their families/whānau wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

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

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

Staff communicate effectively with residents and work in an environment that is conducive to effective communication. The residents and their families/whānau rights to full and frank information and open disclosure from the staff is demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family/whānau and the community. Residents have access to visitors of their choice.

There is a complaint process and register which complies with the required standard.

### **Outcome 1.2: Organisational Management**

Taslin NZ Ltd has a current governance and quality plan which sets out their strategic and quality goals. These are consistent with a facility which provides rest home level care and support to people under age 65 with physical disabilities. There is an appropriate management structure and plan for any temporary absence of either of the two owner/managers or the care manager, who is experienced at the facility and knows staff and residents well.

The quality and risk management system implemented at Otatara Heights meets the requirements of these Standards. There is reporting of all exceptions to expected service delivery and data is collated and analysed. This information is shared with staff, and when relevant residents, so that any trends are identified and issues can be addressed appropriately. There is calendar of internal audits which monitors all aspects of service delivery at Otatara Heights.

There are effective human resources management systems which guide the recruitment and appointment of staff members, orientation and ongoing training, performance management, leave provisions and other aspects of employee management. There is a comprehensive programme of training, competency assessment and appraisals in place.

Staffing levels are appropriate to the needs of residents and this is confirmed at interview with them and staff members.

Each person has an individual clinical file, which is maintained in a timely manner, held securely and confidentially and includes all necessary information to provide safe care.

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

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. If residents' needs exceed the care able to be provided at this facility they are reassessed and transferred as required.

The service meets the requirements and timeframes for assessment, care plan development and evaluation of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes. There is an area requiring improvement relating to evaluation of care six monthly, including documenting the resident's response to interventions and progress towards meeting their goals.

Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks.

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Residents are provided with food, fluid and nutritional services that are reviewed as being suitable to meet the nutritional needs of the older person. Residents receive additional or modified nutritional requirements, special diets and food that takes into account the resident's likes and dislikes.

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

Waste and other hazardous substances are managed appropriately and safely. Staff members have access to supplies of personal protective equipment and there are guidelines for management.

There is a current building warrant of fitness for the facility and building safety checks are maintained. All electrical equipment is checked regularly and hot water temperature in residents' basins and bathrooms is monitored. An area requiring improvement is identified in relation to three of the bathrooms, to ensure that they remain safe for use by all residents.

There are adequate numbers of toilets and showers for residents to use, and there is a separate, and identified staff and visitors' toilet. Personal bedrooms meet residents' requirements for space and accommodate mobility equipment for those people who use it. There are three lounge / dining rooms, which accommodate the needs of the residents on a day-to-day basis and when there are large celebrations.

Cleaning and laundry services are effective and timely. Staff members are rostered to undertake these tasks on a daily basis, throughout the week and the facility is noticeably clean and tidy. Cleanliness is monitored by the care manager through regular internal audits. A recent initiative is cleaning and laundry staff members completing their own daily and weekly checklists so that they also are monitoring their own work.

Essential and emergency systems are in place and have been tested during a recent region-wide power outage. There is an evacuation plan which is regularly practised, emergency food and water supplies on site, fire evacuation training, emergency power and cooking sources. There is a call bell system which, although not used frequently by residents, is responded to by staff when activated.

All rooms have external windows overlooking a garden. Windows open to allow in natural light and ventilation and there is electric heating. Residents report being satisfied with the environment at Otatara Heights.

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

There are systems for the assessment, use and monitoring of restraints at Otatara Heights, however on the days of audit there are no residents using restraints. The organisation has an identified restraint coordinator and is able to utilise these systems, should they be required.

There are three residents who use enabling equipment voluntarily, and all appropriate systems and documentation are in place to support this occurring safely, as required by these Standards.

#### **Outcome 3: Infection Prevention and Control**

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually.

There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The service's policies and procedures comply with relevant legislation and current accepted good practice.

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

There is a monthly collection of surveillance data for infections. The surveillance data is collected, collated and analysed, with results communicated to staff. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. The service has clear procedures to deal with outbreaks.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	43	0	2	0	0	0
<b>Criteria</b>	0	87	0	2	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	5	0	0
<b>Criteria</b>	0	0	0	0	0	8	0	4

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 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	PA Low	Ten of ten files reviewed do not show specific evidence of evaluation of assessments and interventions of care plans. The care plans are documented as reviewed but no evidence is seen	Amend documentation to ensure evidence of specific evaluation of care plans.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		outcome.		of the changes that are made as required to care plans assessments or interventions.		
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	Three of the four bathrooms require remedial work. Two bathrooms have deterioration in the floor base (underneath the floor covering) and one bathroom needs to updated so that it better meets the needs of people at Otatara.	Repair the floors in the two bathrooms and remodel. Update the third bathroom so that it can be used by residents who require assistance from staff when bathing.	180

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: 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:**

Policy identifies staff have on-going education related to resident rights.

Residents' rights at Otatara Heights Residential Care includes a Code of Consumers' Rights that replicates the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Staff receive education at orientation and at in-service training sessions (in-service education planner sighted for 2014).

The service's compliance with the Code is monitored through resident and relative satisfaction surveys which confirms satisfaction. Six of six residents and two family members interviewed confirm satisfaction with the service.

The care manager and caregivers interviewed report knowledge of residents' rights. Observed during the provision of care, were residents being given choices, residents' decisions being respected, residents being treated with respect, residents' privacy being protected, and residents being addressed by a preferred name. Clinical staff are observed to explain procedures being undertaken and seek verbal acknowledgement for the procedure to proceed prior to it being commenced.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

**Attainment and Risk:** FA

**Evidence:**

Residents are made aware of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) in the admission pack. Brochures and posters are on display and are accessible to all personnel entering Otatara Heights Residential Care. This information is also included in the residents' information booklet, as is a copy of the complaints procedure, that is handed out to all admitted and prospective residents, prior to admission.

A list of interpreters is available through the East Coast District Health Board (ECDHB) should assistance be required to provide the information in a language and format that is suitable to the consumer.

Information about the Nationwide Health and Disability Advocacy Service is displayed, accessible and brought to the attention of the resident.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The abuse and neglect policy gives clear definitions and guidelines of managing any incidents or suspected incidents of abuse or neglect of residents. It states that management will do everything possible to prevent abuse and neglect and to address any episode of it, efficiently and effectively. A dignity and privacy policy requires the visual privacy and personal space of residents shall be respected and observed at all times and staff will facilitate the use of private space for interaction with visitors and significant others. All interaction of a personal and private nature should be conducted in an environment affording privacy and dignity. A specific sexuality and intimacy policy and the spirituality and counselling policy in which residents will be encouraged to maximise expression of their values and beliefs both meet all the requirements.

The care manager and owner will investigate and access external support or advise if needed. The employment agreement and house rules (sighted on-site), outlines consequences of actions involving abuse and neglect. Staff training on abuse and neglect is sighted on the education plan for 2014. Interviews with six of six residents and two of two relatives confirm they have no concerns related to abuse, neglect, discrimination, harassment.

ARC Contract requirements are met.

All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. As observed, staff close doors when undertaking personal cares and discussions. There is a mobile telephone that residents can take to their rooms, enabling residents to have privacy when making phone calls. There are locks and signs on all toilet and bathroom doors and staff always knock on their door prior to entering.

Care planning interventions sighted in ten (six rest home and four younger persons with a disability (YPD)) residents' files reviewed and interviews with residents and staff, confirm time is allowed within care provision to encourage residents to be as independent as possible, whilst ensuring their safety. Six of six residents and two relatives interviewed describe being given choices over many aspects of their daily living, being able to choose what they wear and when they do things.

#### **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 states its purpose is to recognize and appreciate the principals of the Treaty of Waitangi. It aims to ensure a Maori Health Strategy based upon partnership, participation and protection for Maori working alongside iwi, hapu and whanau developing and providing culturally appropriate health and disability services. It provides five goals to be met when working with residents and gives the four an outline of the cornerstones to Maori health that are recognized in health service delivery. It also gives guidelines as to procedures to be followed on the death of a Maori resident. A checklist is provided to ensure residents are supported appropriately along with contacts in the community and the DHB for support if need

The one Maori resident at Otatara Heights advised he does identify with his Maori culture. He reports that he is given the opportunity to be in contact with iwi and whanau and reports being extremely happy with the care given to them.

Staff receive annual education in relation to cultural safety and the Treaty of Waitangi. This is on the annual training for 2014 in April and August 2014 and on the nine files sampled the staff have attended this training (except for one staff member who has only commenced worked after the August training was delivered.)

ARC Contract requirements are met

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

The organisation plans to ensure Māori receive services commensurate with their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)**

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

**Attainment and Risk:** FA

**Evidence:**

The organisational cultural safety policy is detailed and requires staff to ensure that the admission nursing care assessment for care planning, will identify a resident's individual values, beliefs and culture, if this would benefit the resident's quality of life in relation to activities and cultural practices, in a sensitive unobtrusive manner. Special care is taken to fully understand a resident's cultural beliefs and previous and current practice of those beliefs, at care planning stages, especially when a resident is unable to express their cultural needs themselves. Staff will receive annual training in cultural awareness across a number of cultures.

As noted previously, eight of nine staff files reviewed show evidence of annual in-service training provided on cultural safety and the Treaty of Waitangi (evidence in the in-service planner show this scheduled in April in August 2014).

Interviews with six of six residents and two of two family members confirm services implemented cover all sexual, intimacy, cultural, religious, spiritual and social requirements and residents have the right to follow their individual beliefs and faith and receive services that recognises their individual values and beliefs.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

There is a policy and procedure on abuse and neglect that provides definitions of different types of both and signs and symptoms. Residents at Otatara are to be protected from abuse and neglect by staff and if staff suspect abuse or neglect is occurring this is to be reported using the incident report process.

Orientation/induction processes include informing staff on the house rules and code of conduct. The staff job descriptions, employment agreement and house rules provide clear guidelines on professional boundaries and conduct. Staff interviewed are aware of Otatara Heights Residential Care's expectations on behaviour and conduct.

Evidence is seen on the 2014 education of elder abuse and sessions by the resident advocacy service. Age Concern have also visited and presented an in-service session for staff in April 2014, and sessions on the organisation's abuse and neglect policy are in the training calendar in May and October 2014.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** FA

**Evidence:**

All staff have an up to date first aid certificates. All staff who administer medication have yearly assessments to determine competency.

Registered nurse education is supported by Hawkes Bay District Health Board (HBDHB) the specialist services that they operate and the local Hospice services. The planned yearly education programme (operating and sighted), includes sessions that ensures an environment of good practice. The cooks have fulfilled the requirements of safe food handling.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The open disclosure policy for Otatara is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process. This is emphasised in the Exception Reporting Policy (Accident/Incident Reporting).

Ten of ten files reviewed provide evidence of resident family/whanau input in the assessment and care planning process, progress notes and communication records of family contact via phone. Incident and accident forms include a tick box to show that family/whanau are informed and that the information has been written into the resident's progress notes.

There is evidence of open disclosure following incidents and family notification. An example is the notification of family when a resident had a fall which required hospital admission to assess for fracture.

Interviews with two of two family members and six of six residents confirm they are happy with the information and involvement they receive from Otatara Heights Residential Care.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A detailed informed consent policy is in place. 'Otatara views informed consent as being a component of quality of life and care and does not support the idea of "general consent" for all treatments. Every resident has the choice to receive services, refuse services and withdraw consent for services. If a resident is cognitively alert they will decide on their own care and treatments unless they indicate that they want representation. Written advance directives (activated when cognitive competency becomes impaired) must be in accordance with common law.' Informed Consent is closely linked with the resident's Code of Rights and Responsibilities. A resident's resuscitative status decision is recorded on a separate consent form after specific process has been followed in line with their resuscitative policy.

Signed consent forms are sighted in ten of ten residents' files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with six of six residents and two of two family/whānau members. The ten of ten residents' files reviewed have correctly signed advance directives or an advance care plan identifying the resident's chosen wishes related to resuscitation status and end of life care. The nine clinical staff (three registered nurse (RN)'s, four caregivers, one cook one activities coordinator) demonstrate their understanding of acting on valid advance directives.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

**Attainment and Risk:** FA

**Evidence:**

Interviews with two of two family/whānau confirm they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family/whānau communication is clearly documented in ten of ten residents' files reviewed, on incident and accident forms sighted and in the staff communication book. The family/whānau, residents and GP interviewed report that communication is a strength of the service.

Evidence is seen of use of family or a support person should the need arise following an incident which differs from the expected care assessment. This can relate to infections that require treatment and the residents at this facility often do not have family so a support person/advocate is available.

Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. At the time of audit there are no residents who require interpreter services.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)**

Consumers are able to maintain links with their family/whānau and their community.

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

**Attainment and Risk:** FA

**Evidence:**

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

Residents are encouraged and supported to maintain and access community services along with friends and family/whānau. Documentation sighted in ten of ten residents' files identifies that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. Some community outings include weekly coffee club group, shopping trips and entertainment. Residents are welcome to have their own spiritual advisor visit or to attend services in the community.

ARC Contract requirements are met.

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

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A comprehensive and clear set of policy, procedures and analysis documents are used by Otatara to manage their complaints process. This includes a user friendly complaints form to make sure the residents and families have a simple process to follow. The availability and contact details of independent advocates are detailed. Clear definitions are given in the policy for complaints open and closed, with who takes responsibility for all parts of the process. The policy provides the platform to ensure that 'residents, families/whanau, visitors and staff are able to express their concerns and complaints in an environment, which is objective, receptive and professional'.

There are complaint forms available within the facility in several locations which are easily accessible, as are copies of the HDC pamphlets on the Code of Rights, the Commissioner and Nationwide Advocacy Service. The Advocate is also involved in visiting the facility and delivering training on the Code of Rights to staff and residents.

There is a complaints register which is maintained by the owner/manager. Complaints are responded to when reported and are recorded on the register. Complaints are acknowledged within five working days of being made. In some cases the complaint is also resolved by this time and the letter reflects the investigation and resolution of the complaint.

The complaint register is up-to-date and reflects access to the complaint process by residents. The owner /manager is interviewed and reports that she takes complaints seriously and investigates them to identify all factors which may be relevant to the issue.

Residents interviewed (six) report that they know how to make a complaint and who to talk to resolve any issues or concerns.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

### **Evidence:**

The governance policy sets out the roles and responsibilities of the directors and the management team with the philosophy of the organisation that 'owners, management and staff aim to provide excellent care in our warm and friendly family home where the care of the young, elderly, frail, confused or physically disabled individuals may live in an atmosphere of respect and friendliness and have their physical, psychological, cultural and spiritual needs met'. Values and mission statements are detailed with all management staff backgrounds given. There is a strategic plan going out three years with the key focus for the current year being to maintain occupancy, reviewing all documentation prior to audit, staffing and service provision reviews, purchase of a new van, refurbishment programme and staff training requirements. Also included are a strategic impact analysis and a medium term vision and plans.

There is a Governance and Quality Plan which was developed by the new owners of Otatara prior to their purchase of the facility in late 2013 and they have implemented and updated this since the purchase and when they took over the running of the facility from 18 November 2013. This plan is reviewed with both owners during the on-site audit and reflects the updates since this time. There are quarterly reports by the owner/manager which link to the updates of the Governance and Quality Plan (See also standard 1.2.3), from February 2014.

The plan has been updated since the purchase of the facility to reflect the change in the management team which now includes the two owners. The care manager - who was the second in charge to the nurse manager under the previous owners - has worked at the facility for some years. She holds the Hauora Certificate in support and has a current first aid certificate. The other members of the management team are two of the registered nurses (RNs) who are taking on some supervisory responsibilities. The two RNs have work experience prior to completing their nursing training. Both worked at Otatara during their nursing training as caregivers and were supported as graduate nurses by the previous nurse manager. They have taken on the responsibilities of infection control and restraint coordinator respectively.

Both the owners have previously leased and run an aged care facility in Hawke's Bay from 2002 through to 2011. Their roles at Otatara are as directors and as facility manager / quality manager / human resource management. Responsibilities include specifically recruitment and orientation and training, kitchen, cleaning and laundry, caregivers, liaison with residents, family/whanau, disciplinary procedures, maintenance, health and safety, purchasing, and payroll. The facility manager holds the National certificate in Support of the Older Person, the ACE (Aged Care Education) Dementia Certificate, Food management and Rest Home management certificates. The manager – maintenance / health and safety, is a registered electrician, has management experience in business as well as aged care, and held a position on the New Zealand Aged Care Association between 2002 and 2011.

All five are interviewed during the onsite audit and demonstrate a sound understanding of the responsibilities of their various roles. They work as a team and have a shared understanding of the vision of Otatara.

During interviews with residents, they report having no issues with the change of ownership and there has been a smooth transition to the new owner / managers. Staff see this as positive and are pleased that residents are settled and have comfortable with the new management team.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility manager and care manager provide cover for one another in a temporary absence from the facility. At interview with the facility manager she describes the arrangements for the two owners when they took two weeks annual leave in June 2014 and the care manager was in charge at the facility with support from the RNs.

Similarly when the care manager is on leave during October 2014 the facility manager and other owner/manager will take on some of her responsibilities, and the RNs will each spend a week as acting care manager, with support from the two owners.

Staff interviewed (seven) report that the management arrangements are suitable and they can access assistance out of hours. During the owners' recent holiday the care manager was the on duty manager and staff report that they were able to access adequate support both during and after hours.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

#### **Evidence:**

The quality plan has been incorporated as a part of the Governance and quality plan 2013/2014 documents. The quality philosophy is to have 'ongoing quality improvement via the implementation of an individualised quality plan, which is simple, relevant, achievable and resident focussed. The plan will result in ongoing improvement to the resident's accommodation, environment, service and holistic care along with improvement to the Home's systems and routines'. There are 19 proposed quality activities to achieve this objective describing how policy, audits, surveys, infection rates, incidents, complaints will all feed into the quality plan which will all be a part of a quality calendar. The quality calendar allows for review of: 'Restraint; Informed Consent; Advanced Directives(including resuscitation decisions); Complaints; Infection rates; Significant Incidents and all accidents; Activities; Suppliers/contractors; operational processes; maintenance; documentation; Finances; Education; Governance and Administration'. A committee will oversee and monitor all quality activity and these actions are then in turn be evaluated for their effectiveness which will lead to improvements in standards, practices and cares. The committee consists of the director, manager, the care manager / privacy officer, infection control officers, RN team and OSH officers.

Occupational health and safety is mentioned in one of the quality committee's functions under OSH/Risk as discussing analysed incident/accident results and recommend appropriate remedial action if appropriate to do so. It is also covered in the health and safety policy. Risk is described as 'the main identified risks encompass non-compliance, competitive/occupancy issues and MOH/DHB funding. Other risks associated with smooth functioning would be identified and analysed in the Risk Manual, which should be read in conjunction with this manual'. The risk manual has a risk policy. All staff are required to read the Risk Manual and sign off that they have done so. Otatara management will keep a Hazard Register, which gives details of prioritized risks, likelihood and consequence scores, potential harm, management controls and training requirements.

There is a quality and risk management system which includes the Governance and Quality Plan of Taslin NZ Ltd, (Taslin) exception reporting processes (incidents, accidents, medication errors, complaints, compliments and infections, use of restraints and/or enablers) regular staff and management meetings where quality improvement data and information is shared and discussed, corrective action planning and the identification and management of risks. The quality management system includes a detailed internal audit calendar and review schedule.

The internal audit calendar is completed by the care manager and includes a comprehensive range of internal audits covering all aspects of the facilities services: including cleaning, laundry and kitchen services, storage of chemicals and food and handling of waste; care plans, risk management, evaluation of plans and resident file documentation; informed consent, advance care directives. The calendar currently has monitoring occurring of key aspects of service in February and August. All scheduled August activities have been completed as planned. Results have been discussed at management meetings.

Policies and procedures have been developed and implemented by the new owners which are aligned with accepted good practice in the aged care sector. The owners and care manager have also developed procedures and work duty lists that link the policies with the actual practice taking place at Otatara. Staff meeting minutes reflect the discussions with staff members at different times when the Taslin policies and procedures have been introduced and discussed with staff. At interview with the owners they report that these discussions will continue for as long as needed. However, with the anniversary of their purchase coming up performance appraisals are due (see also standard 1.2.7) and they have developed and implemented duty lists for each shift. All documents, policies and procedures provided for the stage one audit and seen on-site are current and have been through the development process described in the organisation's document management and control system.

The key components of service delivery as required by this Standard are monitored through the organisation's quality management system. Prior to the purchase of the facility by the current owners and earlier in their ownership, staff meetings were not regular and were largely used by staff members to raise their own concerns and resident care

issues, the management meetings which included the owners, care managers and two RNs noted in standard 1.2.1, were regular and included collation and analysis of quality improvement data.

Over the last four to six months more structure and routine has been introduced into daily hand over meetings, daily hand over meetings, the staff meetings, as well as the management meetings. Information from staff meetings is also in the staff communication's book which is key component of the communication with staff across all shifts each week.

There is evidence of collated exception data from May – July 2014 on display for staff to review. The care manager reports that previous months' data was collated but was removed when this quarterly data was put on display. At interview with seven staff they report receiving this collated data and that it informs discussions about resident support and interventions. They are encouraged to report any incidents or accidents which occur and are kept informed of trends.

Corrective action plans are developed in response to results of internal audits and these are identified in response to some of those completed in August 2014. The incident /accident and complaint forms include a section for correction action in response to the event being reported. Management meetings minutes also include details of corrective actions being taken in response to individual events which have occurred, and trends which have occurred, in particular relating to some of the processes around the laundry and cleaning. This has contributed to the development of the work duty lists for the caregivers, cleaners, laundry staff to clarify these roles. (Prior to the purchase by Taslin, the caregivers could be responsible for any of these areas on any given day they were rostered on duty. See standard 1.2.8 for further information.)

There is a detailed risk management plan which identifies relevant risks the business and the facility's ability to deliver a high standard of care and support at all times. The plan has been reviewed (in August 2014) since its implementation. There are appropriate risk mitigation and management strategies for the identified risks.

ARC Contract 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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The accident/incident reporting and investigation policy requires that all incidents, near misses and accidents are reported and recorded on the appropriate forms. All accidents causing serious harm will be reported to OSH/Department of Labour whether the accident involves a staff member, resident or visitor. Clear definitions are given and a standard form is used to provide all relevant details.

Otatara management requires that any resident harmed as a result of a mistake or an error is to have the circumstances associated with the event fully and frankly disclosed to them and / or their family/whanau.

Adverse event reporting is included in the organisation's orientation and there are six sessions during the 2014 training. These sessions cover any changes which are made to documents, policies and procedures or are updates and refreshers on these for staff members.

The Taslin incident reporting and complaint report forms have more detail on them than the previous forms used by staff. The records of adverse events are reviewed with the facility and care manager during the onsite audit. These demonstrate a good level of reporting by staff, with improvement over time in the detail recorded on each report form.

Each month all adverse events are summarised by event type and the data is graphed and this information is provided to staff via the handover meeting, at the monthly staff meeting and at the management meeting.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There are detailed human resource management processes which describe the recruitment, appointment, induction, orientation and ongoing training of all staff. Employee leave provisions and all aspects of employment practice are included in these processes. As with the other documentation sighted before and during the onsite audit, they are current and up to date, and reflect good employment practice and the requirements of current legislation.

Professional qualifications are validated at appointment and evidence of RNs' registration and annual practicing certificates (APCs) is maintained on personnel files by the facility manager and care manager. Of the seven personnel files sampled two are for RNs and there are copies of their APCs on both their files and both are current. The RNs are working within their scopes of practice with no restrictions.

There has been a low turnover of staff with the change of ownership which has meant stability for residents. Several new staff have been appointed and files for two part time staff (one in the laundry and one cleaner) are included in the sample of nine personnel files sampled. Both have had an induction to the organisation, are attending staff training as it occurs and have worked in other aged care facilities and so are familiar with the key components of service delivery in the aged care sector. (Review of their personnel and training records confirms the completion of induction processes and training.)

There is a detailed annual training programme which commenced in January 2014 and includes the delivery of range of internal presenters (the facility manager, care manager, RNs) on staff who have delivered sessions on the organisation's procedures standards of care, catheter care, fire evacuation procedures, the abuse and neglect policy, hazard control, sexuality and relationships, back care (for staff), hearing aid and ear care, tikanga Maori and te reo Maori and the Treaty of Waitangi.

There are external presenters who deliver other sessions, including: the local HDC advocate delivering a session on the Code, the V J Distributors representative delivering a session on the cleaning and laundering products used at Otatara, Age Concern, first aid training delivered by a qualified external trainer, a session on the Code of Conduct by

a RN from Hawke's Bay District Health Board (HBDHB), incontinence products and their effective use, use of the Medico Pak by a representative from Douglas Pharmaceuticals, dementia and mental health, diabetes, multiple sclerosis, Down syndrome. A session on food handling has been held in early September 2014 for all staff, as a refresher, including for the cook and kitchen staff. From time to time other staff may be required to assist with serving meals and assisting people to eat.

The range of training reflects the requirements of these Standards, an introduction to the organisation and a refresher for longer serving staff on core topics. The RNs are supported to complete their required professional development hours with additional training attended externally to Otatara. One of the five RNs has submitted her professional development 'PDRP' programme requirements and had it assessed and been accepted and another states that she is going through the process of submitting hers, although she has not yet had it assessed.. (Her current APC expires on 31 March 2015 and so there is still time for this to occur.) The other two RNs are being encouraged by their colleagues and managers to complete their PDRP requirements as well, but are new to Otatara having commenced work during 2014.

The care manager maintains records of each staff member's attendance at training and their annual competency assessments. These record a broad range of competencies, including medication administration and controlled drugs; hand-washing and infection control; manual/safe handling; civil defence procedures; fire safety, drills and warden's responsibilities; dealing with complaints; handling and managing chemicals; documentation and policies and procedures.

There are a range of clinical competencies which are completed by staff who are involved in the direct delivery of care, including: blood sugar levels and insulin administration; catheter and uridome care and application; bowel care, including suppositories, enemas and stomas; personal cares/toileting/showering and use of incontinence products and wound care and dressings.

Competencies for staff are up to date and current. Some new staff have not yet completed all required competencies but they have completed all required training that is expected of them given their length of time at Otatara. The Clinical Manager (CM) monitors the completion of competencies by all staff and maintains the records in relation to this.

Those staff employed as domestic staff or maintenance staff (kitchen, cleaning, laundry, gardening, maintenance) complete core training and any training specific to their positions on an annual basis. The activities coordinators complete this staff and both hold current first aid certificates.

Nine personnel files are sampled, including two new staff members recruited since the new owners took over in November 2013. There is evidence on all files of each staff members APC (if required /appropriate), a recruitment process which reflects the organisation's process at the time of appointment, a current performance appraisal, current training and staff competencies as noted above.

Seven staff members, as well as the three managers, are interviewed. They state that the training provided allows them to remain current with their roles and provides an opportunity to refresh information and learn new information. Topics are relevant to the needs of the people they support and the opportunities for ongoing professional development allow them to continue to build their skills, knowledge and experience.

The owner / managers are aware that while they have relevant skills, knowledge and qualifications, they do not hold clinical qualifications. They have been investigating the options for accessing experienced clinical advice and have arranged for a recently retired but experienced registered mental health nurse to be available as a resource person / advocate to the facility. They have also contacted the Hawkes Bay District Health Board's gerontology nurse specialist and have entered into a relationship whereby they will access their advice and clinical expertise when needed. These arrangements are commencing from late September 2014.

ARC contract requirements are met.

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**Finding:**

**Corrective Action:**

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

**Criterion 1.2.7.5 (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:**

An analysis and review of staffing levels planning document contains the organisation's rationale for recruitment and present staffing levels. Their policy is to maintain a pool of part time staff to avoid the need for agency staff. There is also a section detailing additional staff available for holiday relief and unexpected staff absence or during an outbreak, as well as contingency planning management.

At interview, seven staff members report that they are happy with the level of staffing when everyone who is rostered to work arrives for work. They report being busy but they feel safe with the rostered levels of staff, and if they feel they need more assistance they can request more staff.

**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, their family/whānau of choice where appropriate, local communities, and referral agencies. The service offers rest home and residential rehabilitation level of care. The service has a pre-entry form which identifies the resident's required level of care. The vacancy and entry requirements are known by the NASC team at the HBDHB. The Care Manager reports on interview they receive a lot of referrals from the local community by word of mouth.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

When entry to the service has been declined, the potential resident and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services. The pre-entry form and discussion with the manager records the reason for declining, contact with the client/family and alternative options are discussed.

The sighted admission agreement contains sections on the conditions in which the agreement can be terminated and changes to the level of care. The services will ensure that if they are no longer able to meet the needs of the resident there will be an appropriate reassessment; the service will assist to find an alternative service provider and ensure the transfer occurs in an appropriate and timely manner.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has commenced the electronic interRAI assessment tool and all RNs have completed the required five interRAI assessment plans. Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the resident. The service has assessment and care planning tools for wound care, pressure area risk, nutritional assessment, pain assessment, continence assessments, short term care plans, falls management and social and activities assessments. New care plans are based on the assessed needs of the resident. The sighted care plans in the ten of ten residents' files reviewed identified personal, physical, psycho-social, spiritual and cultural needs of the resident.

The ten of ten residents' files evidence that the initial assessment and initial care plan are conducted on admission, with the long term care plan developed within three weeks of admission. The assessment and care plan are reviewed and updated at least six monthly. Where required, the residents are reviewed by a GP within two working days of admission, then at least monthly or three monthly where assessed as stable.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Each shift has a verbal handover and there is a written handover sheet which identifies care requirements including any required changes. Each shift there are entries into residents' progress notes. The seven care staff interviewed (three RN's and four caregivers) report they receive adequate information at hand over.

Tracer Methodology Rest Home:

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

Tracer methodology Rehabilitation:

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

ARC contract requirements are met.

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p>
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**Finding:**

**Corrective Action:**

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

### **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:**

Coombes falls assessment forms are sighted and procedures to help reduce falls incidents. The service has an incontinence assessment and management plan. There are a full suite of procedures around activities of daily living and clinical care to guide staff actions. The Norton scale is used for skin care assessment along with procedures on how to prevent pressure areas. Wound care policy and procedures include a wound care assessment, care plan and monitoring sheet. The service has a pain assessment tool and monitoring chart. The service uses a behaviour assessment and monitoring form.

New care plan assessment documents ensure the needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for care planning and service delivery. The ten of ten residents' files reviewed have assessment tools completed to develop the long term care plan and reassessment occurs at least six monthly, or earlier if there is a change in the resident's needs. The service also utilises other appropriate assessment tools to assess residents' needs. These include wound assessment, pressure risk, and nutrition and falls assessment.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The long term care plan and short term care plans sighted identify the supports and interventions to achieve desired outcomes, as confirmed in the ten of ten residents' files reviewed. One resident reviewed has a care plan and short term care plans that describe the required interventions to suit their needs. The ten of ten residents' files reviewed identify that care planning is individualised to reflect resident's assessed needs and interventions and support systems are clearly shown. Interventions are detailed and interviews with the seven care staff (three RN's and four caregivers) confirm the information ensures continuity of care. Interviews with six of six residents, two of two family/whānau and the GP report care is provided by staff that have excellent knowledge and skills.

The ten of ten files reviewed demonstrate service integration. Residents have one main folder that contains their medical information, nursing assessment, care plan, routine observations, activities, therapies, multidisciplinary reviews and correspondence including off site consultations. There is integration within the progress notes and files, with input recorded from the care staff, GP, laboratory results, referrals and specialist consultation.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A continence management policy is in place. This presents the philosophical view that Otatara believes in promoting continence where possible, supporting residents who are incontinent, managing incontinence effectively and with dignity. The use of specialists as required and staff training along with guidelines to promote continence are included. Policies and procedures for managing challenging and disruptive behaviour and pain management are supported by relevant assessment tools. The grooming and personal hygiene policy also includes checks for skin integrity alongside the skin management policy which gives the process for promotion of skin integrity with assessment and management of any skin problems. The management of wounds policy states that 'wound management will promote optimal progressive healing and pain associated with a wound will be managed effectively and minimised'. There is detailed policy and procedure that outline the steps to be completed upon the death of a resident. It covers who should be notified and what documentation is required. The management and assessment of falls policy aims to minimise the risk of each resident falling and to enable efficient management of falls and residents who fall frequently. A suite of clinical management policies and procedures includes assessment on admission, weight and bowel management, clinical notes and referral information.

The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The ten of ten care plans reviewed confirm care planning is individualised and personalised to be a true reflection of resident's assessed needs. When required, additional short term care plans or clinical pathways are utilised where there is a specialised need (eg, falls minimisation and end of life care). As observed at the time of audit, the care is resident centred and residents are given choices of times and type of care interventions.

Interviews with the four caregivers confirm they use documented interventions to provide appropriate care for each resident. If an intervention is not working well it is reported to the CM who then evaluates the resident's progress and resources current accepted best practice to assist in resolving any issues. The six of six residents and two of two family/whānau confirm they are highly satisfied with care and interventions provided by the service. Residents stated all their needs are met. Comments from residents include the service provides a very personalised service that respects their individual needs.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. The activities coordinator has been employed for seven years. She was employed first as a caregiver and then as the activity coordinator. She has commenced her diversional training through Careerforce and attends two monthly networking groups from within the area. Evidence is seen of attendance at study days relating to activities training. The group and individual activities are based on what the resident wants to do, with a strong emphasis on community activities and outings that reflect the interests of the residents.

The ten of ten residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file six monthly. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. Residents are also observed at the time of audit to be engaging in independent activities, such as going out into the community, reading, listening to music and doing exercises. The six of six residents interviewed express satisfaction with the activities programme.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** PA Low

**Evidence:**

Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans. Short term care planning is sighted for infections, falls minimisation, acute conditions and wound care as confirmed in the notes of the resident reviewed. If the interventions are not working well they are changed and staff are informed. The six of six residents and two of two family/whānau interviews confirm that they have very high satisfaction with the care provided.

Ten of ten care plan evaluations sighted are documented, resident-focused but evidence is not seen to indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcomes. There is an area requiring improvement relating to no specific evidence being in files relating to evaluation of assessments and interventions.

ARC contract requirements are met – other than in relation to the documenting of evaluation progress on residents' files.

**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:** PA Low

**Evidence:**

Ten of ten files reviewed do not show specific evidence of evaluation of assessments and interventions of care plans.

**Finding:**

Ten of ten files reviewed do not show specific evidence of evaluation of assessments and interventions of care plans. The care plans are documented as reviewed but no evidence is seen of the changes that are made as required to care plans assessments or interventions.

**Corrective Action:**

Amend documentation to ensure evidence of specific evaluation of care plans.

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

**Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

**Attainment and Risk:** FA

**Evidence:**

Referrals are made to other medical services by the clinical manager (CM), registered nurse (RN) or GP as appropriate. Records of referrals are sighted in ten of ten residents' files reviewed. Health services accessed include general medicine, surgical services, cardiology, radiology, dietitian, mental health, ophthalmology, immunology and oncology. The GP confirms that appropriate referrals to other health and disability services are well managed at the service.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Risks are identified prior to planned discharges (confirmed by interview with the CM). There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family/whānau or resident want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision and intervention requirements and is sent with the resident as appropriate. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The medication management policy and procedure clearly describe the processes to ensure safe administration of all medications at Otatara. This includes competency requirements, prescribing, recording, process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. A specific controlled drug administration policy ensures controlled drugs are prescribed by a Medical Practitioner who holds written authority to prescribe controlled drugs according to the related legislation and regulations. These meet the legislative requirements. There are no controlled drugs on site on the day of the audit.

The service implements the medicine management process according to the policy and procedures. A safe medicine administration system is observed at the time of audit (observed a RN administering the medicines).

The medicines are dispensed by the pharmacy in a pre-packed system. The packs are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines) are individually supplied for each resident. The medication packs and other non-packed medicines are checked for accuracy against the prescription by the RN when they are administered. The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly which he signs for on the resident medication chart. Standing orders are not used at this facility.

The medicines are stored in a locked cupboard in the RN clinic. The medicine fridge is monitored for temperature, with the weekly temperature recordings complying with guidelines.

Sample signature verification is recorded for all staff who administer medicines. All prescriptions are computer generated by the pharmacy and they allow a safe medication administration process to be undertaken by staff. The prescriptions are legible, record the name, dose, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify resident allergies recorded.

The RN's are responsible for medicine administration at the service. All staff who administer medicines have a current medication competency.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The Kitchen and Food Handling policy states the 'Food handling areas and practices will meet the requirements of The Food Act 1981 and The Food Hygiene Regulations 1974'. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is to be carried out.

Policy identifies that food is served according to a three week rotating menu with summer/winter variances. Policy identifies that the RN's are responsible for managing weight loss/gain with dietitian input sought where weight loss is more than 5% in three months. Weight loss is managed with GP input as appropriate. Specific nutritional requirements are recorded in residents' files. Annual food satisfaction surveys are conducted and feedback is used to make changes to the menus to ensure resident input. A kitchen cleaning schedule is sighted.

Every resident has a nutritional assessment review on entry to the service (and reviewed when indicated) and all residents are routinely weighed at least monthly. The cook also asks the residents what they would like for meals. There is a kitchen audit that includes feedback on the quality of the meals. Interviews with six of six residents confirm they are satisfied with the food service and that their likes and dislikes are catered for. They report that if there is something they do not like, there are always alternatives offered.

Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The diabetic or special diets are clearly specified. The owner has organised for the menu to be reviewed this year.

There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. When food is decanted from its original packaging, the food is stored in food safe containers, labelled and dated. Any food that is returned to the fridge is covered, labelled and dated. Kitchen staff have completed food safety qualifications and receive ongoing education.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A waste management policy describes the rubbish and recycling system that is managed by Hawke's Bay Waste Management Bins and Recycling and is emptied every Monday, Wednesday and Friday. The process for the waste management of bodily fluids is detailed as is the process for needles, scalpels and razor sharps which will be discarded directly into the puncture proof sharps container. When this is three quarters full the Care Manager will arrange for collection and replacement by Southern Community Laboratory. A director is designated as the Waste Management Officer for Otatara. All staff are required to wear protective clothing when handling all waste and chemicals. Bulk chemicals are stored in the outside shed at the back of the property, with one month's chemicals stored in a locked cupboard opposite the laundry. A separate policy on storage and use of chemicals and poisons requires staff to comply with specific practices, reporting and training to manage the safe use of chemicals and other hazardous substances.

There are supplies of personal protective equipment available throughout the facility. These are sighted in the laundry, in storage, in the kitchen on the cleaner's trolley. Ample supplies are seen and are in use by staff members during the on-site audit.

At interview with the facility manager and care manager, they report that the Taslin policy and procedure, although it has been updated and written by the new owners, reflects the practice in place for the management of waste and hazardous substances which staff members are familiar with. At interview with cleaning team member they describe the organisation's policy and procedures and how they were trained in them. They are observed using personal protective equipment while completing their tasks during the onsite audit visit.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

### **Evidence:**

The transportation policy states the circumstances in which transport will be provided for residents and what is the responsibility of families. When transport is provided by the facility transportation vehicles must be registered, warranted and safe. 'All drivers must have a current driver's licence and be unaffected by drugs or alcohol, and be over the age of 25. The Manager will approve and authorise specified drivers'. All vehicles will be checked monthly to ensure that the warrant and registration is current, the oil and water are full, the fire extinguisher is current, the first aid kit is complete and generally check the safety and condition of the vehicle.

There is a current building warrant of fitness which is on display. This was issued on 15 October 2013 and expires on 1 November 2014. Records of the monthly monitoring of the required system checks by the fire and building systems contractor are reviewed with the owner manager responsible for these systems. He demonstrates a sound knowledge and understanding of the requirements of the building standards, the contracts and these standards in relation to the provision of facilities for people with disabilities and older people.

Monitoring of hot water in residents hand basins in their bedrooms and in bathrooms is also carried out by the owner / manager. These records are sighted with him and demonstrate consistent monitoring. Any variations – higher or lower than acceptable levels - are adjusted to within the accepted range.

The facility is a purpose built building on one level which has been constructed around a central garden / courtyard area. There are gardens around the outside of the building and all areas are safe and accessible. There are handrails throughout building and wide corridors. A number of residents use different mobility equipment including wheelchairs and walking frames. Several need assistance to walk. The environment promotes safe mobility whatever their needs.

The gardens are maintained to a high standard and present a visually appealing environment for the residents at Otatara. There are several areas with shade available and there is outside seating.

There are four shared bathrooms which have hand rails and accessible vanity units. However, in two of the bathrooms patches of flooring underneath the floor covering has degraded and needs repair. Another bathroom is original from the time the building was first constructed and now no longer meets the needs of residents. It requires an upgrade to be consistent with the other three bathrooms and to enable staff members to safely provide assistance to residents when this is needed. An area for improvement is identified in relation to these issues

At interview with residents (six) they report satisfaction with their environment. The 2014 resident satisfaction survey confirms this, with the environment receiving a highly satisfied, satisfied rating from respondents.

ARC Contract requirements are met – other than in relation to the bathrooms.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

In two of the four bathrooms small patches of flooring underneath the floor covering have degraded and need repair.

Another bathroom is original from the time the building was first constructed and now no longer meets the needs of residents. It requires an upgrade to be consistent with the other three bathrooms and to enable staff members to safely provide assistance to residents when this is needed.

Residents do not mention the bathrooms and the issues have not made them un-useable or unsafe in any way. Similarly, there are no incidents of infections or accidents related to the flooring issues, hence the low risk rating for this finding.

**Finding:**

Three of the four bathrooms require remedial work. Two bathrooms have deterioration in the floor base (underneath the floor covering) and one bathroom needs to be updated so that it better meets the needs of people at Otatara.

**Corrective Action:**

Repair the floors in the two bathrooms and remodel. Update the third bathroom so that it can be used by residents who require assistance from staff when bathing.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

The facility at full occupancy can take 40 residents. There are three large bathrooms with showers and a toilet in each one, and another toilet co-located next door to each bathroom, but separate. There is a fourth small shower only and two separate toilets next to one another adjacent to the lounge. These are all resident bathroom / toilets.

There is one staff / visitor designated toilet in the facility. During the audit visit this is used by the audit team and is adequate for the number of staff and visitors as well as the audit team members during this time.

All toilets and bathrooms have locks and signage so that privacy is maintained with the bathroom /toilet is in use.

Two of the four showers have problems in relation to the concrete flooring underneath the shower lining, which require improvement. A third shower / bathroom is original and is no longer fit for purpose and requires a full refurbishment so that, if needed, staff can assist residents when they use this bathroom. This area for improvement has been raised under standard 1.4.2.

As noted, residents report satisfaction with their environment at Otatara.

ARC Contract 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:**

Residents all have single rooms. All are personalised to the individual and people are able to bring their own furniture and other possessions if they choose to do so. People who use mobility equipment can move about their bedrooms with their equipment and staff can assist them, if needed, and use mobility equipment such as hoists.

The design of the building means that there is variation in the size and layout of the bedrooms. There are two bedrooms which have connecting doors which have been removed. These bedrooms are occupied by a parent and child at their choice. Both have appropriate assessments for receiving subsidised care. These rooms are of sufficient size to accommodate each person's bed and furniture and neither room has compromised space in being adjacent to the other.

ARC Contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Otatara has two lounge areas, a large one by the main entrance to the facility, which can accommodate all residents if needed, and a smaller lounge / TV room which can be used by up to 10 or 12 residents at a time. There is also a large dining room. All three areas were used throughout the time of the onsite audit visit.</p> <p>A small group of people take their evening meal in the large lounge. This has minimised some of the issues which were occurring in the dining room with different people sharing tables, or not wanting to share tables, and sitting with people whose company they prefer.</p> <p>Adjacent to the front door there is an area with comfortable chairs which gets afternoon sun and has views of the garden courtyard and the comings and goings of the facility.</p> <p>In the recent 2014 resident and family/whanau satisfaction surveys there is a high level of satisfaction with the environment at Otatara.</p> <p>ARC Contract requirements are met.</p>

#### **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 laundry policy provides definitions of the various categories of laundry to be managed appropriately. These are dirty, soiled, infectious, kitchen and clean laundry types. All linen will be transported to the laundry in covered, colour coded bins. The laundry has 'clearly identified clean and dirty areas'. The 'dirty' side, where dirty or soiled linen is transported to is away from the kitchen entrance. It houses the dirty sorting area, two washing machines, tub, hand basin and dirty linen transporting trolley and bags and dirty lined rubbish bin. The sluice area is annexed off this dirty side. The clean laundry houses the clean sorting area, linen cupboard, drying racks and 'clean' linen transporter. The flow is simple, practical and sequential.

New washing machines and dryers have also been purchased and installed in the last six months and these have increased the size of each load.

Since the beginning of August, cleaning and laundry staff have been required to complete a checklist of their daily, weekly and monthly tasks so that they can monitor the effectiveness of their own work. There is a cleaning audit which is used by the care manager to audit the cleaning and laundry of the facility. This audit is completed 6 monthly. This was most recently completed, as scheduled on the internal audit plan, in August 2014. It confirmed that the organisation's processes for cleaning and laundry are both being followed and conducted to the standard expected.

The care manager and facility manager report at interview that they are in the facility daily, Monday to Friday and are checking the cleanliness of the facility, rooms, communal areas, bathrooms, the kitchen and laundry whenever they are in these areas.

Staff observed using the laundry during the audit visit follow the correct flow and other linen handling and laundry procedures. At interview a laundry team member reports that the new layout is easier to work with and has improved the ability of staff to manage the laundry requirements throughout the day.

ARC Contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Fire evacuation procedures are included in the annual training calendar three times across the year. All staff complete an annual competency on fire safety, fire drills, the role of the warden and emergency response. 29 of 39 staff have had this competency assessed so far this year. The remaining 10 staff are not due to renew the competency until later in 2014 and so are still current.

There is an approved evacuation plan, approved by the local Fire Department on 1 December 2004. The evacuation scheme is still current and is practiced as noted. There is a detailed emergency plan which describes the response and actions to be taken in a range of civil defence emergencies including earthquake's, bomb threat, theft, burglary, intruders, power failure, chemical spills, fire, flooding, Tsunami, storm and missing person.

There are alternative energy and utility sources available in the event of main supplies failing which include a petrol powered generator (stored off-site at the owners' home) along with 20 litres of fuel. This was used recently during a Hawke's Bay wide power failure to run the lights in the facility; two large domestic barbeques which are powered by three, nine kilogram gas cylinders; there is 760 litres of water available onsite using the water in the four hot water cylinders and additional stored water in the kitchen store room.

There is a call system in the facility which is activated in each bedroom. There is a light board display outside the care manager's office and adjacent to the kitchen, dining room and nurses' station. During the audit visit the call bell was activated on a few occasions and responded to promptly each time.

ARC contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All bedrooms, the dining room, kitchen and both lounges have large windows which look out onto gardens – either the external garden or the internal garden courtyard. The corridor around the front half of the building has a glass wall on one side which looks out onto the garden courtyard as well.

All windows can be opened to allow air to flow. Windows allow light and are of normal proportion or are larger than normal in the communal areas.

As noted in standard 1.4.5. in the recent 2014 resident and family/whanau satisfaction surveys there is a high level of satisfaction with the environment at Otatara.

ARC contract requirements are met.

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

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

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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**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.

<p><b>Attainment and Risk:</b> FA</p> <p><b>Evidence:</b></p> <p><b>Finding:</b></p> <p><b>Corrective Action:</b></p> <p><b>Timeframe (days):</b>     <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>
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## NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

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### 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 restraint minimisation policy states that 'Otatara prefer only considering introducing restraint as a safety measure and not as a behavioural management tool'. Definitions of restraint are clear and objectives and indications for use of restraint are detailed. It is Otatara's intention to remain restraint free with the understanding that the policy is available for implementation is required. The policy demonstrates a clear understanding of the legislative requirements and the processes to be followed should any type of restraint be used.

There is a policy and procedure on the use of enablers, which includes a definition and it also meets the requirements of these standards.

There are no restraints in use at Otatara at the time of the audit visit. The systems for the assessment of need, implementation, monitoring, quality review and approval of restraints are in place, should restraints be required at any time. There is a restraint coordinator for the facility; currently this is the care manager.

There are three people who use lap belts as enablers with their wheelchairs. The files for these three residents are reviewed with the care manager and the care manager is interviewed.

All three residents who use enabling equipment have this recorded in their Lifestyle care plan, as is required by the organisation's policy and procedure for the use of enablers. These residents use their enablers voluntarily and this is recorded by their consent to their care plan.

ARC contract 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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters within the organisation leading to the senior management. The infection control coordinator is the RN and included in her job description is this role, responsibilities and accountability for infection matters (sighted).

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. The annual review was last conducted in May 2014. The annual review covers quality improvements, policies, procedures, surveillance, staffing, standard precautions and education.

Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. There is a policy for staff not to come to work if they are unwell, there is a notice at the front door advising visitors not to have contact with residents if they are unwell or have been exposed to infections, and at times residents may be isolated where possible and practical. The seven care staff interviewed demonstrate good knowledge of infection prevention and control

### 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 meeting is incorporated into the staff meeting. The infection control coordinator communicates the monthly infection control report to the staff through monthly email notices. The infection control coordinator has the range of skills, expertise, and resources necessary for the implementation of the infection control programme. The infection control coordinator reports that advice was sought from the GP, DHB and infection control specialist on the management of scabies.

#### 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:**

An infection control policy sets out the expectations the organisation will use to minimise infections. A RN will manage an infection control programme which will be comprehensive and include preventative, interventionist and management strategies for infection control. This is supported by an infection control manual and a large suite of

policies and procedures that deal with specific areas including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning disinfection and sterilisation, laundry and standard precautions. They are easily understood and appropriate for services requirements.

The seven clinical staff report on interview they have knowledge of infection control and attendance at in-service is sighted. The service utilises updates from an aged care consultant to review their organisational policies. The staff observed at the time of audit demonstrate good infection prevention and control techniques and demonstrate good knowledge of policies and procedures for infection prevention and control.

The residents report on interview that they are aware of the need to report infections as they may need to stay in their room.

### **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:**

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. The infection control coordinator and specialist infection control resources are utilised for the staff in-service education. The infection control coordinator attends ongoing education on infection control, the most recent in May 2014. The infection control coordinator demonstrates knowledge of current best practice for infection prevention and control.

Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control coordinator has conducted informal education with residents, such as education on the recent scabies management. The seven care staff interviewed report they receive adequate education on infection prevention and control.

**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:**

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. The monthly surveillance data is collated and analysed by the infection control coordinator.

The surveillance data and analysis of infections for 2014 records are sighted. The service would seek infection control and outbreak advice from the DHB and GP in the treatment and management of the outbreaks or infections. The action plan for the outbreak management includes contributing factors to the event, treatment, review of systems and the environment.

#### 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.)*