

# Masonic Care Limited - Woburn

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Current Status: 30 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

Woburn Masonic Care is one of four residential care facilities in the lower North Island owned and operated by Masonic Care Limited. The facility provides hospital and rest home level care for up to 57 residents, with 55 residents on the day of audit. There have been no changes to the management or facilities since the last audit.

There are no areas requiring improvement identified, with continuous improvement noted at criteria level, related to the analysis of quality improvement data, nutrition management, increased uptake of influenza vaccination and surveillance activities to detect and manage infection outbreaks.

## Audit Summary as at 30 September 2014

Standards have been assessed and summarised below:

### Key

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

### **Consumer Rights as at 30 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 30 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 30 September 2014**

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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### **Safe and Appropriate Environment as at 30 September 2014**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### **Restraint Minimisation and Safe Practice as at 30 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 30 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 30 September 2014

### **Consumer Rights**

Care provided to residents at Woburn Masonic Care is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Woburn Masonic Care does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is known to the service and facilitates regular residents' meetings. Woburn Masonic Care encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

The service has an easily accessed, responsive and fair complaints process which is documented and complies with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code of Rights).

### **Organisational Management**

The facility is led by a cohesive senior management team, inclusive of clinical staff, who have been in these positions for a minimum of six years. The facility manager is an experienced manager and registered nurse (RN), supported by two charge nurse managers and a stable nursing and support staff workforce.

Recruitment processes are well documented and observed to be implemented including referee checking, police vetting of all staff and ongoing performance appraisals to monitor performance. Education is well supported and available to all staff, and is inclusive of a comprehensive orientation programme and a requirement for caregivers to enrol in the Aged Care Education (ACE) education programme on employment.

Staff levels are based on contractual requirements but also reflective of resident acuity with process to alert management to potential staffing shortfalls. Recent reviews of staffing and rostering have been undertaken, with all nursing staff now rotating through night duty and additional part time staff to increase flexibility and availability. The nursing roster includes a charge nurse manager across all days of the week and weekend.

Policies and procedures are in place for all aspects of service delivery and are known and understood by staff. The quality of service delivery is the responsibility of a designated RN/quality coordinator. Firm links have been established with the management teams of the other facilities and the development of board wide policies that are reviewed and updated as required.

The facility demonstrates a strong commitment to health and safety of residents and staff, and a quality and risk management programme to mitigate any identified risk and to monitor identified key performance indicators, some of which are clinical indicators. Data collected from the internal audit programme are reviewed by the facility, across the other three facilities as a comparison to level of attainment and potential areas for improvement. This data is also provided to an Australasian organisation that compares data and provides reports to the facility. The management team are committed to quality and a cycle of ongoing improvement where data is analysed, reviewed and results in improvements are formally evaluated. The facility takes an innovative approach to receiving feedback and demonstrates that feedback from all sources, including staff, residents, the district health board (DHB), family members and from complaints, is acted on and results in improvements in service delivery. This has resulted in a continuous improvement achievement rating.

Residents' admission information is accurately recorded, stored securely and not accessible to the public. Resident notes are legible, dated and signed, providing a record that includes the necessary, up-to-date information and clearly documents that care provided meets the assessed needs of the residents.

### **Continuum of Service Delivery**

Information packs for Woburn Masonic Care contain information on entry criteria, fees payable, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment and Services Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. All residents' file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family.

An activities programme, that includes a wide range of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents

The menu has been reviewed as meeting the required nutritional guidelines by a registered dietician. An initiative to address residents' weight loss and dislike of nutritional supplements has been identified as an area of continuous improvement. Residents need for feeding assistance or modified equipment is recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

### **Safe and Appropriate Environment**

Whilst the facility is old in years, there is a proactive programme of maintenance and renewal of equipment and rooms. The building warrant of fitness is current, with processes in place for the safe management of waste and hazardous substances. Emergency equipment is available along with provisions and water set aside for use during a disaster or an emergency. Staff attend regular training about fire, health and safety, and emergency procedures including trial evacuations.

Rooms are of an adequate size, allowing for personal items. Each room has an ensuite toilet and basin with close access to showering facilities. Heating is provided by a radiator heating system, which allows for personal heat settings in the rooms and communal areas. Lounge and dining facilities are large and spacious with smaller seating areas scattered throughout the facility. Residents have ease of access to the well-kept gardens and grounds. A large recreation room is available along with a library and a designated, ventilated smoking room.

Cleaning services are provided by a well-established external provider with a programme of quality control to ensure standards are maintained. Personal residents' laundry is managed on site, with a linen service provided by an outside laundry service. The facility is observed to be well maintained, clean and uncluttered.

### **Restraint Minimisation and Safe Practice**

The facility has a policy that reflects the minimisation of restraint. At the time of audit there are no residents who have restraint as a part of service delivery, with it documented that bed rails are the only restraint permitted. Policies, procedures, appropriate documentation and staff education are in place to ensure that if restraint is required, the standards for safe restraint use, assessment, monitoring and evaluation are implemented.

### **Infection Prevention and Control**

The service is able to demonstrate it provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the facility manager who reports to the CEO.

There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse/ quality co-ordinator is responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate. An area of continuous improvement is identified around resident education and uptake of influenza vaccinations.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed, and this is also an area identified as one of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance.

# HealthCERT Aged Residential Care Audit Report (version 3.92)

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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>	Masonic Care Limited
<b>Certificate name:</b>	Woburn Masonic Care
<b>Designated Auditing Agency:</b>	DAA Group Ltd
<b>Types of audit:</b>	Certification Audit
<b>Premises audited:</b>	
<b>Services audited:</b>	
<b>Dates of audit:</b>	<b>Start date:</b> 30 September 2014 <b>End date:</b> 1 October 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	16
<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	16	<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	32	Total audit hours off site	28	Total audit hours	60
Number of residents interviewed	10	Number of staff interviewed	23	Number of managers interviewed	6
Number of residents' records reviewed	8	Number of staff records reviewed	11	Total number of managers (headcount)	6
Number of medication records reviewed	16	Total number of staff (headcount)	48	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Tuesday, 21 October 2014

## Executive Summary of Audit

### General Overview

Woburn Masonic Care is one of four residential care facilities in the lower North Island owned and operated by Masonic Care Limited. The facility provides hospital and rest home level care for up to 57 residents, with 55 residents on the day of audit. There have been no changes to the management or facilities since the last audit.

There are no areas requiring improvement identified, with continuous improvement noted related to the analysis of quality improvement data, nutrition management, increased uptake of influenza vaccination and surveillance activities to detect and manage infection outbreaks.

### Outcome 1.1: Consumer Rights

Care provided to residents at Woburn Masonic Care is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Woburn Masonic Care does not currently care for anyone who identifies as Maori but has appropriate policies, procedures and community connections to ensure culturally appropriate support can be provided if required.

Residents receive a high standard of care and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively with them and residents are kept up to date. Residents sign a consent form on entry to the service with separate consents obtained for specific events.

A local independent advocate is known to the service and facilitates regular residents' meetings. Woburn Masonic Care encourages residents to maintain connections with family, friends and their community and encourage people to access as many community opportunities as possible.

The service has an easily accessed, responsive and fair complaints process which is documented and complies with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code of Rights).

### Outcome 1.2: Organisational Management

The facility is led by a cohesive senior management team, inclusive of clinical staff, who have been in these positions for a minimum of six years. The facility manager is an experienced manager and registered nurse (RN), supported by two charge nurse managers and a stable nursing and support staff workforce.

Recruitment processes are well documented and observed to be implemented including referee checking, police vetting of all staff and ongoing performance appraisals to monitor performance. Education is well supported and available to all staff, and is inclusive of a comprehensive orientation programme and a requirement for caregivers to enrol in the Aged Care Education (ACE) education programme on employment.

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The facility demonstrates a strong commitment to health and safety of residents and staff, and a quality and risk management programme to mitigate any identified risk and to monitor identified key performance indicators, some of which are clinical indicators. Data collected from the internal audit programme are reviewed by the facility, across the other three facilities as a comparison to level of attainment and potential areas for improvement. This data is also provided to an Australasian organisation that compares data and provides reports to the facility. The management team are committed to quality and a cycle of ongoing improvement where data is analysed, reviewed and results in improvements are formally evaluated. The facility takes an innovative approach to receiving feedback and demonstrates that feedback from all sources, including staff, residents, the district health board (DHB), family members and from complaints, is acted on and results in improvements in service delivery. This has resulted in a continuous improvement achievement rating.

Residents' admission information is accurately recorded, stored securely and not accessible to the public. Resident notes are legible, dated and signed, providing a record that includes the necessary, up-to-date information and clearly documents that care provided meets the assessed needs of the residents.

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

Information packs for Woburn Masonic Care contain information on entry criteria, fees payable, service inclusions/exclusions and residents' rights. The organisation works closely with the Needs Assessment and Services Co-ordination (NASC) service to ensure access to service is efficient whenever there is a vacancy.

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. All residents' file sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family.

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

Whilst the facility is old in years, there is a proactive programme of maintenance and renewal of equipment and rooms. The building warrant of fitness is current, with processes in place for the safe management of waste and hazardous substances. Emergency equipment is available along with provisions and water set aside for use during a disaster or an emergency. Staff attend regular training about fire, health and safety, and emergency procedures including trial evacuations.

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Cleaning services are provided by a well-established external provider with a programme of quality control to ensure standards are maintained. Personal residents' laundry is managed on site, with a linen service provided by an outside laundry service. The facility is observed to be well maintained, clean and uncluttered.

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

The facility has a policy that reflects the minimisation of restraint. At the time of audit there are no residents who have restraint as a part of service delivery, with it documented that bed rails are the only restraint permitted. Policies, procedures, appropriate documentation and staff education are in place to ensure that if restraint is required, the standards for safe restraint use, assessment, monitoring and evaluation are implemented.

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

The service is able to demonstrate it provides a managed environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the facility manager who reports to the CEO.

There is a clearly defined infection prevention and control programme for which external advice and support is sought. An infection control nurse/quality co-ordinator is responsible for this programme, including education and surveillance.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate. An area of continuous improvement is identified around resident education and uptake of influenza vaccinations.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed, and this is also an area identified as one of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	4	89	0	0	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	0	0	5
<b>Criteria</b>	0	0	0	0	0	0	0	8

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The organisation takes a consistent, planned approach to quality improvement which demonstrates that data and feedback gathered is reviewed and used to inform quality improvement activities which are demonstrated to benefit service delivery, residents, families and staff.
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	Implementation of a quality initiative regarding residents losing weight has resulted in an improved uptake of high caloric drinks and residents weight loss stabilising (in five of 12 results) or increasing (in seven of 12 results).
HDS(IPC)S.2008	Criterion 3.4.5	Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer.	CI	An initiative to increase the uptake of flu vaccines in residents has resulted in no incidents of flu at Woburn during the winter months of 2014.

Code	Name	Description	Attainment	Finding
		Where applicable a record of this education should be kept.		
HDS(IPC)S.2008	Criterion 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.	CI	A quality surveillance initiative to detect and manage outbreaks and reduce the impact on residents has been implemented and resulted in effective and improved outbreak management.

# 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:**

Woburn Masonic Care Limited (Woburn Masonic) is observed to provide an environment in which residents receive services in accordance with human rights legislation.

Management (six of six) and staff (17 of 17) are familiar with the Code of Health and Disability Services Consumers' Rights (the Code) as evidenced during conversation with them and in sighted policy documents.

Staff receive education on the Health and Disability Commissioner's Code (the Code) at orientation and through the "full day" yearly in-service training programme as sighted in staff records (11 of 11 employment, orientation and training records) and planned education programmes, and verified by interviews with staff. Residents (two of two hospital residents, five of five rest home residents) and family/whanau (four of four hospital and three of three rest home residents family/whanau) interviews verify the service complies with consumer rights legislation.

Clinical staff are observed to explain procedures being undertaken, seek verbal acknowledgement for a procedure to proceed prior to it being commenced, protect residents' privacy (eg, notes being locked away, confidentiality of information, private areas to make phone calls, staff knocking on residents' doors prior to entering their rooms), and address residents by a preferred name.

Compliance with the Code is monitored through resident and relative satisfaction surveys.

The ARRC 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:**

Woburn Masonic provides an environment in which residents are informed of their rights. Residents are made aware of the Code and the Nationwide Health and Disability Advocacy Service with information displayed throughout the facility, in all residents' rooms and accessible to all residents, as observed.

Residents receive a copy and of the Code and information on the Nationwide Health and Disability Advocacy service on admission, with opportunities for discussion, clarification and explanation available at admission and any other time as necessary. Information is also provided on, access to support services, information on long term residential care for older people, information on applying for a residential care subsidy, and the facilities range of services and costs. Legal advice is able to be sought on the admission agreement or on any aspect of the service at any time.

Advice to accessing interpreters is available should assistance be required to provide the information in a language and format that is suitable to the resident.

The facility has a residents' advocate who is onsite every ten weeks, and runs the residents' meeting. She is able to be contacted at any time if a resident requests to see her (as verified by staff, residents and family interviews and interview with the residents' advocate).

The ARRC 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:**

Woburn Masonic provides an environment in which residents are treated with respect, and receive services that has regard for their dignity, privacy and independence. All bedrooms occupied on the day of audit are single occupancy and allow privacy for residents at any time. Bedrooms are of a size that allow appropriate storage of personal belongings. As observed, staff close doors when undertaking personal cares and discussions. There are locks on all toilet and bathroom doors and staff always knock on their door prior to entering. The nurses' stations provides privacy of stored information. Privacy when discussion concerning residents takes place, is in residents' rooms or in one of the many private lounge areas. Staff education on privacy takes place at orientation, and during the full day yearly in-service schedule that operates at Woburn Masonic.

Residents receive services that are responsive to their needs values and beliefs.

Care plans identify residents' like and dislikes and interventions identify the assistance the resident requires to meet residents' needs, while being encouraged to be as active as possible

Residents are addressed in a respectful manner and by their preferred names, are assisted to maintain dignity and respect and to ensure sexuality, spiritual, cultural and intimacy needs are both supported and protected, while protecting the wellbeing of others.

Residents are kept free from discrimination, harassment and abuse within an environment that supports evidence-based practice. The individual employment agreement, Code of Conduct, job description and company policies and procedures identifies the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. There are no concerns expressed related to abuse or neglect.

Residents have access to visitors of their choice and are supported to access community services. The environment is one that enhances and encourages choice, opportunity, decision, participation and inclusion of the resident, as evidenced by resident participation in the various initiatives.

Staff demonstrate an awareness of the need to provide a service that is responsive to these needs

Evidence of this is observed, sighted in resident and staff files reviewed, residents meeting minutes and verified in resident advocate, resident, family and staff interviews.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**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:**

Woburn Masonic recognises the special relationship between Iwi and the Crown; and appreciates the principles of The Treaty of Waitangi (Partnership, Participation and Protection). The service acknowledges the Treaty of Waitangi and the Treaty partnership between Maori and all others must be ongoing.

There is a Maori health plan (sighted) that includes policies and procedures for all stages of service provision. The organisation's model of care ensures residents who identify as Maori have their individual values and beliefs acknowledged, respected and met by the service. Advisors from Waiwhetu Marae advise and assist if needed. There are no residents at Woburn Masonic who identify as Maori at the time of the audit.

Staff receive annual education in relation to cultural safety and the Treaty of Waitangi.

The requirements of the ARRC 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:**

Woburn Masonic provides an environment that enables residents to receive culturally safe services which recognise and respect individual ethnic, cultural and spiritual values and beliefs.

Included in the admission, and ongoing assessment process, residents and/or family/whanau are consulted about individual values and beliefs. Any special cultural, spiritual, values and beliefs requirements needed to be met by the service are identified and documented to inform the care planning and activity planning process to ensure those residents' specific needs and objectives are met.

Clergy of all denominations visit regularly; a multi-denominational roster of church service is sighted in the activities programme. Other requests can be arranged with management and some residents' families access their own spiritual support from the community. Open visiting policy allows family/whanau to visit when they are able. Staff receive yearly in-service training on cultural safety and the Treaty of Waitangi.

Evidence to support findings is sighted in resident file reviews, nutritional profiles and staff training records. Resident and family/whanau interviews confirm staff implement cares to meet their needs.

The ARRC 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:**

Woburn Masonic provides an environment that is free of any discrimination, coercion, harassment, sexual, financial or other exploitation, including policies and procedures which are implemented by the service.

Orientation/induction processes inform staff on the Code, the house rules and the Code of Conduct. The employment agreement refers to the Code of Conduct which refers to company policies and procedures and provides clear guidelines on professional boundaries and conduct, and informs staff about working within their professional boundaries. A signature acknowledging the terms related to all this information is located in all employment agreements. The manager will action formal disciplinary procedure if there is an employee breach of conduct.

Residents receive a high standard of support and assistance. Residents feel safe, there is no sign of harassment or discrimination, staff communicate effectively and residents are kept up to date, as evidenced in staff files, observed at audit and verified in staff, resident and family interviews.

The ARRC 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:**

Woburn Masonic provides an environment that encourages good practice. All policies sighted are up to date, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. They are reflective of evidence based rationales, which are monitored and evaluated at organisational and facility level.

Human resources are managed to employ competent employees. New employees complete a comprehensive orientation/induction programme that is relevant to the role being undertaken. Staff records evidence competent employment practices, orientation and training records. The service supports and encourages staff with appropriate on-going education relevant to the role they undertake. The service has an extensive and diverse in-service education programme in place which is monitored at organisational level to ensure all key components of service delivery are covered to meet contractual requirements and residents' need. Staff interviewed, confirm their orientation/induction education and training prepared them for the roles they undertake. Staff state they are encouraged and supported by management to undertake education that is of interest to them and that assists them to undertake their roles in a professional understanding manner.

Incident reporting systems are evidenced to be linked to open disclosure and quality improvement processes.

All care staff have or are undertaking aged care and dementia training by a qualified onsite trainer and assessor. Registered nurses (RNs) who administer and/or check medication have yearly assessments to determine competency (sighted). Senior care staff have yearly medication competencies to administer medications to rest home residents and enable them to "check" accuracy of medication for the RNs where the medication is to be checked for accuracy by two persons (sighted). Two senior caregivers are also sighted to be deemed competent in a range of nursing practices under the guidance of the RN.

RNs have an up to date first aid certificates (sighted). Ongoing education for RNs is supported by the facility, the District Health Board, the specialist services that they operate and the local Hospice services.

Kitchen staff have qualifications in Safe Food Handling

Residents and relatives interviewed verify satisfaction with the services provided and resident satisfaction surveys undertaken annually indicates overall satisfaction with the service.

An interview with the GP, verifies satisfaction with the services provided. The service responds promptly and correctly to requests and is prompt in requesting input if needed.

The ARRC 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:**

Woburn Masonic provides an environment conducive to effective communication.

Communication with relatives is documented in the communication sheet which is kept in the resident's file (sighted). Incident and accident forms evidence resident and/or family are informed of incidents. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Staff confirm they understand that relatives and residents must be informed of any changes in care provision by the RNs.

There are no residents that require interpreting services, however management staff are aware of how to access interpreters if this service should be required.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

On admission the resident and their family/whanau are given information and a discussion is held to provide information and clarify any areas of concern.

Residents and family interviews confirm communication with staff is open and effective, that they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews (sighted in files reviewed) eight of eight resident and seven of seven family interviews, and sighted during audit.

The ARRC 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:**

Woburn Masonic provides residents, and where appropriate their family/whanau, with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in service, in addition to providing a booklet informing residents and families of the services provided and this is sighted in the residents' rooms. Residents are able to choose their GP of choice. The RN discusses information on informed consent with the resident and family/whanau on admission. Consents requests the resident's agreement to: collect and retain information; for a photograph for identification purposes; a name on a bedroom door; and to travel in transport organised. Informed consent is evident in observation of activities at audit, with residents being actively involved in the decision making process.

Files reviewed evidence informed consent forms signed on admission and identifies that resident, and where desired family/whanau, are informed of any changes to care including medication changes. Medicine charts (10 hospital and six rest home) have resident's photographs for identification. Residents' choices and decisions are recorded and acted on. A 'good palliative care order/resuscitation form' captures residents input into planned future care and enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The form is filled out in consultation with the resident's doctor and residents' consent or non-consent can be revoked at any time. The form is sighted in files reviewed. Verbal consent is obtained prior to an intervention being carried out as observed and verified in clinical staff, residents and family interviews. Care plans are signed by the resident and/or family/whanau, where appropriate, to say they have read and agree with what is written.

Staff education on consent takes place during their orientation and during in-service education. Staff have an understanding of the informed consent process and confirm their understanding of the resident's right to privacy, to be treated with respect and dignity and to be fully informed of all care procedures. The environment is observed to be one where choices are offered and openly acknowledged.

Resident and family interviews confirm they are provided with the necessary information to make informed choices, choices are respected by staff and staff confirm they respect the resident's right to decline refuse consent at any time.

The consumer satisfaction survey results, sighted, indicate family/whanau satisfaction with involvement in care.

The ARRC 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:**

Woburn Masonic recognises and facilitates the right of residents to advocacy/support persons of their choice. Residents are informed of their right to advocacy services during their admission. They are instructed on their right to contact the Health and Disability Commissioner's office if they feel their rights have been breached and have not been dealt with in a satisfactory manner. Advocacy information is included in the information booklet. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally.

A resident's advocate visits Woburn Masonic every 10 weeks and runs the residents' meetings. She is available at other times if needed and residents are aware of how to contact her. An interview with the residents' advocate verifies Woburn Masonic's recognition, facilitation and responsiveness to advocacy services.

Residents and their families are aware of their right to have support persons, as verified in clinical staff, residents and family interviews.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service provides an environment whereby residents are able to maintain links with family / whanau and their community. Residents are assisted and encouraged to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations. The service acknowledges values and encourages the involvement of families/whanau in the provision of care and the activities programme actively supports community involvement and accesses community resources.

Resident and family interviews confirm that visitors can visit freely and there is free access to community services. It is observed that there were visitors coming and going from the facility during the audit. File reviews, the manager, RN and the recreational officer confirm community services used by the facility include:

- local social groups,
- the local community centre activities
- other aged care facilities
- local church groups and services
- the Hutt Valley District Health Board (HVDHB) nurse specialists
- the local needs assessment and service coordination agency (NASC)

- the service has a podiatrist and physiotherapists who visits regularly
- residents have the GP of their choice
- HVDHB outpatient and inpatient services as appropriate.

The ARRC 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:**

Policies and procedures are in place to support the implementation of a complaints management system that demonstrates a proactive approach to the management of complaints. A complaints register is maintained and routinely reviewed, with evidence that for the small number of complaints received, appropriate processes are followed within a timely fashion, and evidence that complaints are satisfactorily resolved.

The manager and clinical nurse managers confirmed an open door policy with residents and family members able to discuss issues at any time. Staff are provided with training on orientation and also as a component of ongoing education. Staff were able to describe the complaints process. Residents and relatives interviewed confirmed an understanding of their right to complain and were able to identify how they could do this.

#### 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:

Masonic Villages Trust is governed by a board of trustees which currently has 10 members with an appropriate mix of skill and expertise in the trustees. There is an ability to co-opt additional members and expertise as required. The Woburn Masonic facility is governed by a smaller board of three trustee members with responsibility under the umbrella of Masonic Care Limited with the Chief Executive Officer (CEO) responsible for all residential facilities within the Masonic Trust. He has been in his position for 10 years, and has an office onsite at Woburn. The board meets monthly, with the CEO confirming that he meets with the chair of the board monthly outside of the planned board meeting. The CEO is a director of the NZ Aged Care Association which supports keeping abreast of health sector issues and the potential impacts on facilities.

The Masonic Care Limited Strategic Business plan (2011-2016) identifies values (benevolence, charity, respect, excellence and integrity), scope and organisational goals to be sustainable, to provide resident centred care, to achieve ongoing quality improvements and to be the best place to work. Each goal identifies specific strategies as well as indicators to identify achievement against the goals. The plan identifies the current sector environment including future drivers for change which is considered in terms of supporting business continuity.

The plan is reviewed annually with the CEO confirming he is currently preparing for the scheduled November 2014 review.

The ARC 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 is managed by an experienced RN with a current practising certificate, who has been in her position for 12 years. This position is further supported by a clinical leadership structure which includes two experienced charge nurses (6 years and 12 years' service). The senior of the two charge nurses is considered to be the second in charge and replaces the facility manager during planned and short notice absences from work. There is a clear understanding of roles and responsibilities of the senior management team.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation has a documented quality and risk management system which is understood at all levels of the organisation. Policies and procedures have been developed based on good practice, whilst ensuring legislative requirements are met. The policies and procedures are available in hard copy, with the quality coordinator maintaining overall document control of all policies and procedures.

Health and safety practices are guided by policy which identifies the roles of the board of trustees, management and all other employees. A Health and Safety Committee is in place and routinely meets monthly with evidence from meeting minutes demonstrating the committee is fulfilling their health and safety obligations for the facility. Meeting minutes are made available for all staff. Committee members have access to specific qualifications and ongoing training. Comprehensive policies are available and cover areas such as accidents, chemical spills, as well as obligations of any on-site contractors. The organisation has achieved ACC Workplace Safety Management Practices tertiary status.

Hazard identification and management is monitored by the Health and Safety Committee, with existing hazards reviewed monthly. Documentation is available to support staff in reporting hazards, as well as any adverse events. All staff are orientated to the health and safety practices required by the organisation.

The organisation has a risk management plan in place which identifies objectives, the risk management process, definitions of and scoring of risks. This information is presented in a current Risk Management Action Plan. All meetings within the organisation (senior management, clinical team, ward based team meetings), include discussions of any health and safety, infection control, or quality issues.

Woburn Masonic has an Organisational Quality Framework in place which identifies the mission, values statement and a quality philosophy for a vision of continuous quality improvement. There is a quality coordinator who has responsibility for driving the quality programme, reporting to a quality advisory group. This role also has access to other quality coordinators at facilities within the Masonic Care Trust. There is evidence of collaborative review of policies and procedures as the organisation moves from site specific documentation, policies and procedures to a board wide programme. This is providing the opportunity to review what is currently in place and to update this as necessary.

Quality improvement objectives are documented, with education provided to all new staff on orientation and as a component of ongoing in-service education. A comprehensive internal audit calendar is in place, with the organisation reporting monthly on key performance indicators, which are sent quarterly to the QPS benchmarking programme. The organisation benchmarks their performance across the facilities, with the DHB (for example, Vitamin D and presentations at emergency department) and externally across Australasia with QPS. The quality plan is reviewed every six months by the management team, with support from the board as required.

A strength of the organisation is their demonstrated commitment to continuous quality improvement with examples demonstrating that quality data (from many sources) is analysed and utilised to improve service delivery. Processes of evaluation are robust and demonstrate a 'closing of the quality loop'. The organisation continues to strive to identify opportunities for improvement, is innovative in their approach to engaging staff and consumers in the quality programme and this forms the basis of a continuous improvement achievement (refer criterion 1.2.3.6).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** CI

**Evidence:**

There is a demonstrated commitment to quality improvement evident from the chief executive to the clinical and support staff within the facility. The quality coordinator (QC) oversees the quality programme with the full support of the senior management team, as well as support from other quality coordinators within Masonic Care Limited facilities. There is a drive by the organisation to develop and embed an organisational wide programme of continuous quality improvement as an efficiency mechanism but also in view of standardising the development and implementation of policies and procedures.

The quality framework clearly articulates the requirements for the collection of quality improvement data, and the processes of internal and external benchmarking. Internally, the facility compares their data with the other facilities in the group, with quality coordinators reviewing the findings and looking for opportunities for learning and improvement from each other. The trending of data enables it to be made clear if there are developing issues which need addressing, as well as monitoring on-going progress, in what is considered a 'no surprises' approach.

All internal audits are supported by standardised documentation that enables the QC to identify any issues, to establish an action plan for improvement and a review once the action plan is completed. This information is made available to management teams, clinical staff, and any improvements are also communicated to the residents and families through the resident advocate, the newsletter and directly to any residents/family where required.

Locally, the facility works collaboratively with the district health board on activities that contribute to better health outcomes for residents. Recent examples include a project on vitamin D usage (Woburn attained a 95% rate), and the review of emergency department presentations of residents (reported to be very low at Woburn). The organisation is also contributing to a research project which is investigating the benefits of vibration training in falls reduction. This is a controlled study with initial showing that those residents who have used the vibration training have reported increased confidence in mobility and increased quality of life.

External benchmarking occurs via the QPS system which is Australasian wide. Key performance indicators are measured monthly and reported quarterly with the organisation provided with a comprehensive report of how the facility is doing in relation to others. Minutes demonstrate that the organisation reviews these reports and considers the information in terms of identifying how further improvements can be made. Two components of the QPS programme have been further expanded as it was noted that response rates for the annual staff and family surveys remained poor and a lack of meaningful qualitative data being provided. Two projects were implemented to increase staff and resident feedback, with evidence demonstrating that qualitative data increased and a greater engagement in the process noted. There is evidence that this process has contributed to improved communication regarding the transfer of patients between the DHB and the facility.

When health and safety audits identified that ward areas were cluttered with equipment not returned to appropriate places and hazards for residents increased, and repeated re-auditing did not demonstrate any improvement, a Tidy Ward competition was implemented. The project ran over a period of three months, with monthly auditing undertaken. Initial response from staff was one of disengagement, however, a competitive culture soon developed with each ward striving to be the best. As a consequence of this competition, further auditing demonstrates that compliance with the required standard is maintained. It is observed on day of audit that the environment is uncluttered, with all equipment appropriately stored ensuring safe resident access through the hallways.

There is also evidence that the organisation uses any adverse events or complaints as a basis for seeking quality improvement. For example, when it became evident that a resident overheard inappropriate communication between a caregiver and a resident during night duty, an investigation of the complaint was completed. As a consequence of this response it was discovered that a 'culture of night duty existed' with long standing staff who only work at night and concluded with a roster review.

There is clear consistent demonstration of comprehensive, innovative approaches to quality with the process of continuous quality improvement utilised on all aspects of service delivery which do not have a significant impact individually but collectively add to enhancing the quality of care. This approach has been applied to issues such as not enough feeder's available, missing personal resident laundry, falls linked to poor slipper footwear, improving the taste of Ensure and reducing the use of agency staff.

**Finding:**

The organisation takes a consistent, planned approach to quality improvement which demonstrates that data and feedback gathered is reviewed and used to inform quality improvement activities which are demonstrated to benefit service delivery, residents, families and staff.

**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:**

Policies and procedures are in place to guide the management of all adverse event reporting. Documents are available to all staff to support the reporting, with education provided during orientation processes for all staff (as evidenced by the orientation programme workbook). Adverse event reporting is a key feature of the health and safety programme, with the organisation demonstrating achievement of tertiary status with the ACC Workplace Safety Management Programme. Incident report data is collected, and analysed for any identifiable trends to inform corrective action plans that may be required. All incidents are reviewed by the health and safety coordinator, along with the senior management team, clinical team, and at registered nurse and ward team meetings. The quality coordinator is responsible for entering the data into the incident reporting system and the external QPS benchmarking system.

The facility is aware of statutory reporting requirements, with a review of incident reports demonstrating that the documented policy is implemented appropriately.

Staff confirmed at interview that they have a clear understanding of the process, roles and responsibilities, and are provided with feedback on any incidents reported. The organisation uses incidents proactively as a way of improving services with evidence of quality improvement activities linked to issues identified via the reporting system.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are sighted which support human resources management. Eleven personnel files are viewed with evidence that recruitment processes utilise the documentation available. Police vetting and referee checking occurs, credentials are validated with evidence that annual practising certificates are renewed annually. Staff are orientated, with the manager confirming that orientation plans and timeframes are tailored to the individual with some staff having longer orientation plans when required. Performance appraisals are completed for all staff.

All staff sign individual employment agreements (IEA), with the manager confirming that the contracts are currently being updated and reformatted and these will be used with new staff. They are also working through existing staff to transfer them to the new contract which includes all documents, such as, code of conduct, health and safety, confidentiality incorporated into the IEA rather than requiring multiple forms to be signed on appointment. The new IEA is sighted.

The quality coordinator is responsible for the development of the education programme (sighted) which shows evidence of meeting mandatory training requirements, education topics that may have been required in response to events or clinical practice issues, as well as ward based training at shift handovers. Attendance is monitored and high levels of attendance occur as the training sessions are planned in conjunction with the roster. All caregivers are engaged in the ACE programme and progress is monitored.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are in place to support the appropriate staffing levels. A recent change has been the assigning of the rostering process to the quality coordinator who is able to apply an acuity tool developed from guidelines. There is recent evidence that the use of this tool was able to confirm care requirements and the appropriate organisation of workload to ensure staff and resident safety is maintained.

Staffing levels are reviewed by the manager and senior clinical team, with a significant reduction in external agency use as a consequence of reviewing base staffing, and given an increase in the part time workforce, there is greater flexibility for staff to work additional shifts. This serves to ensure a stable workforce and continuity of care. It is noted that if a potential staffing shortfall may occur due to sick and unplanned leave, the acuity tool is used to identify the potential for working with the existing staff. The QC is able to take into account the skill level of all nursing and care staff when completing the roster.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents admitted to Woburn Masonic have the information relevant to their circumstances recorded on the day of admission and always within 24 hours of admission (three of three rest home and five of five hospital resident files reviewed). The residents' records contain information to safely identify the residents, it is legible and dated. Integrated notes on the resident's progress are completed by care staff and by the registered nurse where registered nurse input is required. These are dated with the time of entry and the designation of the staff member making the entry recorded.

Resident information is kept in hard copy format. The registered nurse deals with resident file content.

The service is not responsible for national health index (NHI) numbers.

All records sighted are secure. Archived files are in a locked room, and easily retrievable and accessible.

The administrator keeps a register of past and present residents which includes details of name, NHI, date of birth (DOB), GP and room number plus admission date and address, next of kin (NOK) and date left service (including discharge address).

All relevant ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Woburn Masonic provides an environment whereby when the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.

Information on the services availability, access and entry criteria are documented and communicated to residents and their family/whanau by Woburn Masonics website, local doctors, referral agencies, HVDHB hospital, the Eldernet website and local community groups. Information includes full details of the services provided, its location, hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.

Prior to entry, the resident must be assessed by Nurse Maude - the Needs Assessment and Service Co-ordination (NASC) agency in the area to ensure they require the care provided.

If a phone enquiry is received from someone who has not been assessed, entry criteria is explained and they are advised to contact their GP or the local NASC agency. All enquiries are documented on a facility enquiry form. Information packs are sent out or given to prospective residents. Prospective residents/family/whanau are encouraged to tour the site and make time for discussion with the Manager or Charge Nurse if she is not available.

Files reviewed (three rest home and five hospital) contain completed assessments by Nurse Maude verifying placement is required.

Admission agreements are signed and sighted in each of the files reviewed. Admission agreements meet contractual requirements.

Resident and family members interviewed confirm they were informed and involved in this process.

The ARRC 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:**

Woburn Masonic has a clear process for informing residents, their family/whānau and their referrers if entry is declined. This has occurred when a bed is not available. The reason for declining entry is communicated to the resident and their family or advocate in a timely and compassionate manner and in a format that is understood. Where able and appropriate, assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services.

The admission agreement, describes when the agreement may be terminated and under what conditions a resident may be asked to leave the facility.

The ARRC 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:**

Each stage of the service provision is undertaken by a suitably qualified provider and is developed with the resident and their family/whanau.

Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) and includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the residents' immediate needs. A medical assessment is conducted by the resident's general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks in which time the RN completes a long term care plan, based on the collection of comprehensive assessment data.

The long term care plan directs the care required to meet the resident's need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care, and the RN (where RN input is required) each shift.

The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents' desired outcomes are being met.

Residents are attended to by their GP of choice. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident's medication is reviewed three monthly or as needs change and this is conducted by the GP.

Family contact is documented in the family contact record. Evidence of this is sighted in files reviewed and verified by interview. Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the resident's care. Ongoing RN training sessions and attendance records are sighted.

Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements, in addition to extensive training in other areas.

The cooks and kitchen assistants have qualifications in food safety training (NZQA 167 and NZQA 168)

The contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Each wing has a charge nurse who oversees the care the resident receives from the RNs and caregivers. The charge nurses (two) at Woburn Masonic ensure onsite coverage and continuity by one or other being onsite seven days a week. Each resident's care is planned and managed by a RN and a key worker (caregiver). A verbal handover by the RN occurs at the beginning of each shift to ensure all staff is familiar with the residents' needs. Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required.

The ARRC contract requirements are met.

Tracer methodology one – hospital resident

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

Tracer methodology two – rest home resident.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Within 24 hours of admission residents have their needs identified through a variety of information sources that includes the NASC assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom.

Over the next three weeks, the RN undertakes more comprehensive assessments including the interRAI assessment. Assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. The physiotherapists and podiatrists assess all new admissions. This identifies the needs outcomes and goals of residents and serves as the basis for care and activity planning.

The assessments are reviewed six monthly as needs, outcomes and goals of the resident change.

A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. Evidence of this is sighted in files reviewed.

Resident and family interviews, verify they are included and informed of all assessment updates and changes.

Staff interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.

The ARRC 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 care plan is developed in consultation with the resident and/or family/whanau, documents the resident's individual plan of care identified by initial and on-going individual assessments, and describes the required support to enable the resident to meet their needs, goals and desired outcome.

Residents' have one set of clinical notes in which all providers involved with the residents care use to document the residents' progress.

Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care provided. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan.

Care plans are evaluated six monthly or more frequent as the resident's condition dictates. Short term problems are included in the long term care plan.

Information from the assessment process informs the allied services of residents' need. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer of interventions required in the activities programme, the physiotherapist is informed of any need for physiotherapy input and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need.

Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included in the planning of their care.

The staff education records sighted for 11 staff demonstrate that staff receive appropriate training. Training records and planning evidence an extensive education programme that includes the Code of Rights, infection control, feeding technique, the palliative care lecture series, wound care, de-escalation of disruptive behaviour, breathlessness, communicating with a resident with dementia, pressure care and equipment, medications in aged care, restraint, diabetes, pressure ulcer prevention, wound care, end of life care, restraint minimization and safe practice, elder abuse and neglect and management of challenging behaviour.

The RNs participate in ongoing professional development with external providers and in-service education by the nurse practitioner.

Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit.

The senior clinical team meets every week and discusses any clinical issues of concern with clinical input initiated if required and verified in meeting minutes and resident files. Education sessions with caregivers occur daily at handover when a clinical issue needs attention. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures

Timely access to other health providers is evident in residents' files, where specialist input is required.

The ARRC 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.

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

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

Service delivery plans demonstrate service integration.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The care and services at Woburn Masonic are delivered in a safe and respectful manner.

The provision of care is consistent with the desired outcomes in residents' files reviewed which document the residents' physical, social, spiritual and emotional needs and desired outcomes. Resident care is reviewed weekly by the senior clinical team if there are clinical concerns and monthly by the RN who is the key worker for that resident. Interventions are detailed, accurate and meet residents' needs and current best practice standards.

Interviews with residents and family/whanau members expressed satisfaction with the care provided and verify new residents are welcomed and orientated to the facility.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted).

The ARRC 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:**

On admission, residents at Woburn Masonic are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident's preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.

The activities programme at Woburn Masonic operates six days a week and is provided by a full time activities officer who is completing the diversional therapy training, and a part time activities co-ordinator. The programme is overseen by a qualified diversional therapist who mentors the trainee.

Activities reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, visits to local cafes and clubs and malls). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate. At present residents' have expressed no interest in craft activities, so none are offered at this time.

Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the residents response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.

A residents' meeting is held every 10 weeks, and meeting minutes evidence that the activities programme is discussed. The yearly resident/relative satisfaction survey also captures feedback on the activities programme. Residents and family are satisfied with the activities offered. The activities co-ordinators interviewed reports feedback is sought from residents during and after activities.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the Charge Nurse or RN, who may contact the GP if requested. Family/whanau are kept informed of changes.

Formal care plan evaluations are conducted by the RN at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident

is not responding to the services or interventions, changes are initiated to the care plan. Short term care concerns such as infections, wound care, changes in mobility and the resident's general condition is added to the long term care plan.

A multidisciplinary review of each resident occurs three monthly or six monthly as determined by the residents doctor, and includes a documented review of all service providers involved with the resident; in addition to the resident and or family.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all care plan updates and changes.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident support for access or referral to other health and/or disability service providers is facilitated to meet the residents need. If the need for other non-urgent services are indicated or requested, the GP or Charge Nurse sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process. Residents are supported to access other health and/or disability support services, and where possible a family member accompanies the resident. The facility has access to a van and can escort residents to appointments.

Residents are given a choice of GP when they are admitted. Most residents use the contracted GP. He visits twice weekly.

Acute/urgent referrals are actioned immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. Families are informed.

The ARRC 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:**

Exit, discharge or transfer is managed in a planned and co-ordinated manner that keeps the resident family/whanau fully informed. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There is a specific transfer/discharge form that records all the relative information needed when transferring a resident. If the resident is transferring to a DHB or another facility, a verbal handover is given. Communication is maintained with family at all times to foster a smooth transition. All referrals are clearly documented in the progress notes.

The ARRC 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 at Woburn Masonic is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.

Medicines for residents are received from the pharmacy in the Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All staff who administer medicines have current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management.

Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed and administered are checked by two medication competent nurses (one an RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly stock take and reconciliation recorded.

The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.

The medicine prescription on charts reviewed (10 hospital and six rest home) is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review records a review of medications.

No residents at Woburn Masonic self-administer their medicines at the time of audit.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No incident of drug errors is evident in incident forms sighted in files reviewed. The manager and charge nurses are not aware of any recent drug errors.

The manager monitors to ensure all staff who administer medications have current competencies. RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in medication administration and checking controlled drug dispensing and administration (documentation sighted), under the direction and delegation of a RN.

Standing orders are not used at Woburn Masonic.

The ARRC 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 food, fluid and nutritional requirements of the residents at Woburn Masonic are provided by an external supplier in line with recognised nutritional guidelines for older people as verified by the dietitians documented assessment (August 2014) of the planned menu, that changes seasonally (sighted). There is evidence observed to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements

Training records verify the cook and kitchen staff are trained in food and hygiene safety (NZQA 168 and 167). There is evidence sighted of recent training delivered to food service staff on 'nutritional needs of the elderly' particularly special dietary needs.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs are sighted.

It was reported by care staff that residents who are prescribed a specific nutritional supplement had lost interest in drinking it and were not showing any evidence of weight gain. A trial was commenced to use 'high calorie nutritional supplement shakes' (HCES) that were more appealing. The shake recipe included honey, yoghurt, banana, ice cream, banana milk, cream and the nutritional supplement prescribed. This increased the calorific value of a 200ml drink from 229.6 calories to 289.6. The dietitian from the HVDHB and the resident's doctor supported the trial. The trial commenced in March 2014. Documented caregiver feedback evidences residents finding shakes more tasteful and residents are now drinking the shakes. Evidence of further benefit is sighted in residents' weight records. Prior to the trial there were 12 residents who were losing weight. Five are now no longer losing weight and seven have had a weight increase. This is identified as an area of continuous improvement.

Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. This is sighted and rosters are reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience.

Food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered daily depending on need and availability and meats and fish are ordered weekly or as required. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC 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:** CI

**Evidence:**

A trial was commenced in March 2014 to use more appealing 'high calorie nutritional supplement shakes' for those residents who are prescribed a specific nutritional supplement and had lost interest in drinking it and were not showing any evidence of weight gain. The shake recipe increased the calorific value of a 200ml drink from 229.6 calories to 289.6. Documented caregiver feedback evidences residents finding shakes more tasteful and residents are now drinking the shakes. Evidence of further benefit is sighted in residents' weight records. Prior to the trial there were 12 residents who were losing weight. Five are now no longer losing weight and seven have had a weight increase. This is identified as an area of continuous improvement.

**Finding:**

Implementation of a quality initiative regarding residents losing weight has resulted in an improved uptake of high caloric drinks and residents weight loss stabilising (in five of 12 results) or increasing (in seven of 12 results).

**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:**

Policies and procedures are documented to ensure the safe management of waste and hazardous substances. The Maintenance Manager confirms the waste management processes are provided by appropriate companies who are responsive to the needs of the organisation and the disposal of waste. The providers can be contacted when there is a requirement to clear waste in between scheduled visits and occurs infrequently indicating the current process ensures the timely removal of waste. Waste processes are known by staff and policies adhered to.

The procedure regarding chemical spills identifies appropriate storage, safety precautions, and procedures for spills including incident reporting. Spill kits are housed in the kitchen and laundry, with the data safety sheets for the chemicals in use sighted in the laundry. Personal protective equipment is observed within the kitchen, laundry and sluice areas, with staff confirming an understanding of the use with education provided on orientation and as a component of infection control orientation. Protective equipment is provided to the gardeners/handyman specific to use of equipment and sprays.

The ARC 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:** FA

**Evidence:**

There is evidence of a planned building maintenance programme that is proactive as well as timely responsiveness to any issues that arise through reporting mechanisms known to the staff. The reporting mechanism ensures that issues are signed off when completed to ensure staff are informed. The proactive and reactive programme ensures the facilities and the environment meets the needs of the residents and the provision of a safe working environment for staff.

There is a current building warrant of fitness. Procedures are in place to audit the facilities monthly to ensure that compliance is maintained and planned maintenance is occurring. The facility is observed to be in reasonable order, gardens and outside areas are clean and well maintained, with ramps provided to support access to outdoor areas and movement around the outside of the facility.

Electrical safety testing and equipment testing is completed as per the documented schedule, including those personal resident items. Transportation of residents is appropriately managed with authorised drivers who have completed the required training in the use of the hoist when using the coach which is appropriately registered and maintains a current warrant of fitness.

The facilities are tidy and well organised to ensure residents are able to safely mobilise around the facility.

The ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

All rooms are single rooms with an ensuite toilet and hand basin. Showers are provided throughout the facility which are adequate to meet the residents' needs. The Manager confirmed that there have not been any reported issues regarding resident's access to showers when required. Signage is available to support resident privacy for the public areas, with doors on all ensuites. A shower trolley is available and is used as part of a resident's plan of care. Designated visitor and staff toilets are available. Additional accessible toilets are available for residents.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All rooms on site are single rooms with an ensuite toilet and basin. The rooms are of varying sizes with some rooms observed to be larger and used for those residents at hospital level where there is a requirement for more space to safely use equipment such as hoists. The smaller rooms are compact, however are observed to not restrict the ability for the resident to personalise the room with their own belongings with sufficient space to move safely with mobility aids if required.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Three lounge and three separate dining areas are provided in the facility. One of the lounges is very large, contains couches and provides space for recreational activities (observed on day of audit). Large screen televisions, stereo, book and DVD library are provided. Toys are available for visiting children. If space is required for family or whanau, a chapel is available for use with staff confirming that they have set the room up for family when required. Seating spaces are scattered throughout the facility and observed to be used by residents. A designated, ventilated smoking room is provided for residents which also provides external access.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility provides on site management of resident's personal laundry and other smaller items, with towels and bedding sent to a contracted laundry service. Stock levels are well maintained and meet the needs of the facility. Processes are in place to manage the personal items including the safe return of items. Caregivers provide the laundry services and have been orientated to the policies and procedures regarding laundry management. All on-site laundry equipment is appropriately monitored.

Cleaning services are contracted with the contractor providing their own staff and taking responsibility to ensure that policies and procedures are followed, performance is maintained and the requirements of the facility are maintained. Cleaning services are audited by the contractor and included in the facilities environmental audit. It is observed that the facility is clean, with cleaners taking the trolley into the rooms to ensure they are not left unsupervised. Chemicals are appropriately stored and labelled, with the Ecolab system in use. A designated washing machine is sighted for the cleaning of mop heads. The kitchen/cleaning manager is a member of the contracted service team as well as the health and safety committee.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility has a designated Fire and Safety Officer with documented responsibilities. The RN in charge is the designated fire warden.

An emergency procedures document has been reviewed in June and includes a staged evacuation plan and the position of all equipment. Stations are affixed to the walls throughout the facility near fire alarm points which include an emergency procedures flipchart guide to the response required in specific emergencies - fire, fire evacuation, earthquake, high winds, to isolate water supply, gas leak/chemical spill/electricity and power, robbery, bomb threat, discovery of unusual objects. Fire alarms are monitored.

In an emergency, a central battery system operates immediately during a power outage providing emergency lighting for one hour. Battery torches are available, providing access to a generator is currently in progress.

The fire system is audited by a designated provider to ensure that compliance is maintained, including conducting trial evacuations 6 monthly. A review of training documents demonstrate that staff training is provided during the orientation process and as part of the annual training update. RNs hold first aid certificates and receive training on emergency responses and the use of emergency equipment which is located in the nursing stations.

All resident rooms contain a 5 litre container of water with 8 additional 20 litre containers kept as part of the civil defence emergency store. The water is replaced as part of an annual audit. Emergency food supplies are kept to ensure a supply of three days, with stock rotated to ensure it remains in date. A large external water tank is observed, with capacity for the tank to capture rainwater if required. The tank is drained and refilled annually.

An internal bell system is provided for residents to call for attention. All external doors open outwards without keys. All doors including the front door are locked after 6 pm with a call system in place to allow visitors to enter after the doors are locked. A security company patrols three times at night. A visitors signing book is in place at the front desk along with a resident signing book to ensure that residents can be accounted for when required.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

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

<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 1.4.8: 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 residents' bedrooms have external opening windows and adequate lighting. The rooms are fitted with controllable radiators with residents reporting that the temperature is adequate and able to be modified to meet their individual needs. Fans are available for use in the summer time with the manager reporting that they are able to sufficiently cool the facility and rooms during the summer months.

The ARC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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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:**

A restraint approval group and coordinator is in place, along with policies and procedures and documents to support the approval, implementation, monitoring and evaluation of restraint. The facility has a policy with a focus on no restraint, and at the time of audit, restraint had not been used for over two years.

Staff have received training in restraint minimisation including de-escalation with staff confirming recent updates and completion of an education package. Education records sighted confirmed the completion of training. The restraint policy indicates that bedside rails are the only approved restraint, with the facility confirming that they do not currently have any beds fitted with side rails.

#### **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:**

Woburn Masonic provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a clearly documented infection control (IC) programme, designed by the IC team that aims at establishing, maintaining and monitoring procedures covering IC practices, monitoring, reporting and analysing data, education and training, cleaning, housekeeping, waste disposal and laundry operations. It is the responsibility of the Infection Control Coordinator who is also the Quality Coordinator to ensure appropriate resources are available (sighted) for the effective delivery of the IC programme and it is her responsibility to implement the programme.

The IC practices are guided by the infection control manual and assistance from the Hutt Valley District Health Board (HVDHB) infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these is sighted at audit. Reporting lines are clearly defined, as verified in staff interviews. The IC Coordinator records monthly infection rate data, as evidenced in files reviewed and infection records, and presents a monthly report to the Clinical team meeting, Management team meetings and RN meetings (minutes sighted). Infection data is

entered into the Quality Performance System (QPS) for analysis and benchmarking. Every three months, the Quality Coordinators and facility managers of all the Masonic facilities meet with the General Manager and these meetings include discussion of infection related data. The IC programme is reviewed annually and is last reviewed in June 2014.

**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 Quality coordinator/Infection control coordinator is responsible for infection control at the Woburn Masonic. A position description is included in the Infection Control (IC) programme and in the quality coordinator's file.

The IC coordinator verifies there are enough human, physical and information resources to implement the infection control programme. She has access to expert advice when required. IC training of the IC coordinator occurs via training offered through an external provider, attendance at conferences, in-service training and guidance offered by the Hutt Valley DHB.

The IC coordinator has access to diagnostic records to ensure timely treatment and resolution of infections.

The IC coordinator facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and in-service records of infection control training for staff. Any IC concerns are reported at the Clinical Team meeting. IC data is collected monthly and entered into the QPS benchmarking system.

### 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:**

Woburn Masonic has an IC programme that is reviewed annually, and includes policies and procedures. These cover infection control surveillance, standard precautions, hand hygiene, safe management of sharps, collection of specimens, infectious spills, needle stick injuries, management of an outbreak, isolation precautions, disinfecting and sterilisation, antibiotic and antimicrobial, influenza, vaccination, wound care, risk management, building renovations, waste management and cleaning and laundry management. All are signed off by the IC coordinator as current.

Staff interviewed are able to describe the requirements of standard precautions and could say where the IC policies and procedures are for staff to consult. Cleaning, laundry and kitchen staff are observed to be compliant with generalised infection control practices.

### 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:**

Staff receive orientation and ongoing education, relevant to their practice as verified by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.

Resident education occurs in a manner that recognises and meets the residents' and the family's communication style. Education to residents on the benefits of flu injection increased the uptake of flu injections to 97% and there was no incidents flu in residents at Woburn Masonic over the past winter as verified by infection records and resident, staff and family interviews. This initiative has been identified as an area of continuous improvement.

There has been recent evidence of Norovirus and MRSA (refer 1.3.7.5) at Woburn Masonic this year and as a result of increased risk an initiative was implemented around hand washing. Education on hand washing and standard precautions was undertaken for staff on all shifts, after which a competency assessment occurred. An infection control website game assessed hand washing occurring at appropriate times in the healthcare setting. All caregivers passed. All RNs sat a quiz on MRSA, two attained 100% and all others exceeded the target of 87%.

**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:** CI

**Evidence:**

Education to residents on the benefits of the 'flu' injection increased the uptake of flu injections by 97% and there was no incidents of flu in residents at Woburn Masonic over the past winter as verified by infection records and resident, staff and family interviews.

**Finding:**

An initiative to increase the uptake of flu vaccines in residents has resulted in no incidents of flu at Woburn during the winter months of 2014.

**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:**

In line with the facility's IC policy and procedures, monthly surveillance is occurring, based on very clear criteria to identify an infection. The type and frequency of surveillance is as determined by the IC programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form as well as a large sheet on the wall in the nurses' station. All infections in the unit each month, are clearly visible to all care staff and quickly identify criteria for analysis. A high number of infections is quickly evident and acted on at handover. Incidents of infections are sighted and are low. These are collated each month, presented to the senior clinical meeting, RN meeting and entered into the QPS system to be formally analysed, benchmarked and discussed at the three monthly Quality meeting. Any actions required are implemented. Findings are presented at board meetings, with any necessary board requirements discussed and actioned. As evidenced by records and verified by staff interviews.

A recent outbreak of MRSA was identified in a resident attending an outpatient's clinic. A wound was noted not to be healing, despite all other factors being favourable. Swab for MRSA was positive and the wound healed after treatment with antibiotics. Another non healing wound was swabbed and positive, it also healed with antibiotic. All residents with wounds or skin conditions were swabbed, with six of ten residents being positive for MRSA. Four staff were swabbed and none were positive. In conjunction with the hand washing initiative (refer 1.3.4) all residents but one are now clear, with the last one expecting clearance soon. Future action involves swabbing slow healing wounds while continuing with staff education.

A recent Norovirus outbreak, results in documented evidence to verify improved management of outbreak and reduced impact on residents staff and families following the previous outbreak. Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed, and this is an area identified as one of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance.

#### 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:** CI

**Evidence:**

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed, and this is an area identified as one of continuous improvement. Surveillance results are reported through all levels of the organisation, including governance. Recent incidents of outbreaks have evidence of improvements in management and decrease in numbers.

**Finding:**

A quality surveillance initiative to detect and manage outbreaks and reduce the impact on residents has been implemented and resulted in effective and improved outbreak management.

**Corrective Action:**

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