

FOMHT Health Services Limited

Current Status: 5 November 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance 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

The Jack Inglis Friendship Hospital continues to provide hospital, rest home and dementia care services to people in the Nelson township of Motueka and its surrounding district. A new wing added in 2012 has seen a reconfiguration of services. On the day of the unannounced surveillance audit 62 of the 73 beds were occupied.

Residents and staff are satisfied with the management of the service and a registered nurse dedicated to the role of quality management oversees the comprehensive and ever developing quality management system.

The five areas, most of which were related to medicine management, that were identified as requiring improvement at the previous certification audit have been addressed, as have two outstanding environmental issues raised at an interim verification audit. There are no areas that require improvement identified in the criteria audited during this unannounced surveillance audit.

Audit Summary as at 5 November 2013

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 5 November 2013

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

Organisational Management as at 5 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

Continuum of Service Delivery as at 5 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

Safe and Appropriate Environment as at 5 November 2013

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

Restraint Minimisation and Safe Practice as at 5 November 2013

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

Infection Prevention and Control as at 5 November 2013

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.
---	--	--

HealthCERT Aged Residential Care Audit Report (version 3.9)

Introduction

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

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

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

Audit Report

Legal entity name:	Friends of Motueka Health Trust		
Certificate name:	FOMHT Health Services Limited		
Designated Auditing Agency:	The DAA Group Ltd		
Types of audit:	Surveillance		
Premises audited:	Jack Inglis Friendship Hospital, 15a Courtney Street, Motueka		
Services audited:	Hospital - Medical, Geriatric and Rest Home, including Dementia Service		
Dates of audit:	Start date: 5 November 2013	End date: 5 November 2013	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			62

Audit Team

Lead Auditor	XXXXXXXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXXXXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	3
Number of residents' records reviewed	14	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	80	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the 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	Yes
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA Auditing Agency has finished editing the document.	Yes

Dated Tuesday, 26 November 2013

Executive Summary of Audit

General Overview

The Jack Inglis Friendship Hospital continues to provide hospital, rest home and dementia care services to people in the Nelson township of Motueka and its surrounding district. A new wing added in 2012 has seen a reconfiguration of services. On the day of the unannounced surveillance audit 62 of the 73 beds were occupied.

Services are being delivered at a high standard. Residents and staff are satisfied with the management of the service and a registered nurse dedicated to the role of quality management oversees the comprehensive and ever developing quality management system.

The five areas, most of which were related to medicine management, that were identified as requiring improvement at the previous certification audit have been addressed, as have two outstanding environmental issues raised at an interim verification audit. There are no areas that require improvement identified in the criteria audited during this unannounced surveillance audit.

Outcome 1.1: Consumer Rights

Open disclosure is occurring according to organisational policies and procedures. Adverse event reports detail the people contacted following such an event and these clearly state the time and date family are contacted. The nature of the discussion is also outlined on these forms. Other instances of open disclosure are recorded in client records and residents state they are kept informed, especially by the registered nurses and the manager.

A policy and procedure of when and how to contact interpreter services is available. This also notes the ability to access the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and information on advocacy services in other languages via the internet.

The complaints process is known by staff and available to people who use the service. When a complaint is made the provider demonstrated review and follow-up including consultation with the complainant.

Outcome 1.2: Organisational Management

A quality and risk management plan is linked to the strategic plan, which details the purpose, values, scope, philosophy and mission of the service. The facility manager is suitably qualified, has been at the facility for over four years, and has previous experience in managing aged care facilities. A quality manager, clinical manager and charge nurse also provide management oversight to the organisation.

Ten manuals of policies and procedures that guide practices are being consistently reviewed and are updated when required. All sighted are document controlled according to organisational requirements.

Staff are kept informed about the quality and risk management system at monthly quality/staff meetings. Reports and graphs are developed from the analysis of quality improvement data and on progress with quality improvement projects. Corrective action processes are being implemented and reviewed according

to plans developed for the purpose. Risks identified in a risk management plan are being reviewed and the hazard register is current.

Staff employment and appraisal processes ensure suitable staff are providing services. Professional annual practising certificates are being checked, a recently updated orientation programme is in place, and a staff training record system provides evidence that identified core training is being offered and attended.

The rosters indicate that a registered nurse is on duty for 24 hours on seven days of the week and there is a high level of support available from registered nurses. The allocation of caregivers in each area is undertaken in accordance with policy and safe staffing guidelines to ensure the safety of residents.

Outcome 1.3: Continuum of Service Delivery

Services are provided by a team of care staff that includes access to a registered nurse 24 hours a day and a resident's identified general practitioner, routinely for three month reviews, as well 24 hours a day when required. Residents have access to a diversional therapist and assistants, physiotherapist, podiatrist and specialist health professionals as required. On admission each resident is assigned a primary nurse who completes a nursing assessment, including the utilisation of a variety of risk assessments. The primary nurse develops an individualised Lifestyle Plan in collaboration with the resident and family which identifies resident focused goals and interventions to achieve those goals. Assessments and care plans are reviewed at appropriate intervals. Service plans demonstrate care is planned to meet the identified needs of the resident and are responsive to a change in the needs or health status of the resident. Residents participate in a diversional therapy assessment which contributes to the development of an activities plan suitable to the needs of the resident, with a wide range of activities available.

The facility has systems and processes in place for the safe prescribing, administration, and storage of medications. Improvements have been made to the process for the recording of controlled drugs contained within individual resident blister packs. Medications are administered by registered nurses and caregivers who have completed a competence assessment, with registered nurses also required to undertake additional medication competencies as a component of on-going professional development. Observed medication rounds demonstrate compliance with the medication administration process, including one resident self-administering medication. Processes are in place to ensure that competence to self-administer is assessed and routinely reviewed. The facility has introduced a modified medication chart which provides an additional page for the recording of 'as required' medications, with space available to document the indication for use and the maximum doses allowable. Corrective actions from the previous audit have been closed.

Food services are provided by an onsite kitchen which has recently been renovated, with new work surfaces, new equipment, and new flooring which has addressed the previous requirement for improvement. The menu is planned in collaboration with a contracted dietitian and reviewed as required. The menu is varied, with a four week rotation and a summer and winter menu. A variety of fluids are readily available to residents. Each resident has a nutritional profile created on admission and identifies any specific needs for the resident, including food preferences, support with feeding and special or modified diets. The kitchen is able to accommodate vegetarian, diabetic, low fat, low fibre/residue, gluten free diets, nutritional supplements, as well as accommodating any ethnic needs.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current building warrant of fitness. A certificate of compliance and a letter of approval from the fire service for the fire evacuation scheme have been issued for the new wing. These address an outstanding issue raised during the verification audit undertaken approximately one year ago.

Outcome 2: Restraint Minimisation and Safe Practice

Definitions on the different types of restraint and on enablers are included in the restraint minimisation and safe practice policy documents. Staff are familiar with the differences and are aware of the processes that need to be undertaken prior to any use of an enabler or a restraint. Approval processes for the use of enablers and/or restraints are being implemented as required and there is evidence of monitoring and review processes. The manager and staff inform that restraints are considered a last resort to ensure the safety of the residents.

Outcome 3: Infection Prevention and Control

Infection control policies and procedures describe the processes for the surveillance of infections. The infection control co-ordinator collects and collates monthly infection data from all areas. Graphs are developed from these records and are displayed in the staff room. Monthly reports that include an analysis of the data are provided to the quality/staff meeting, when the infection control coordinator takes the opportunity to deliver brief but on-going infection control updates, on the importance of hand washing and correct disposal of soiled linen, for example. Overall infection control rates are low. The manager provides a summary on infection prevention and control surveillance and education in her reports to the Board.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	61

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited

Evidence:

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: Not Audited

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: Not Audited

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: Not Audited

Evidence:

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: Not Audited

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: Not Audited

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: Not Audited

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: Not Audited

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: Not Audited

Evidence:

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: Not Audited

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: Not Audited

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited

Evidence:

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: Not Audited

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: Not Audited

Evidence:

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: Not Audited
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: <p>A policy for open disclosure is sighted and is linked to the policy on adverse events. This states the circumstances in which open disclosure will occur and notes the need to include documentation in the resident's record. Six examples of open disclosure being written onto the pink 'Communication with families' record sheet are sighted on residents' files. Staff are oriented to this policy when they commence work in this service. On the bottom of the adverse event form under 'follow-up actions' there is a section of tick box options that includes options, such as manager, family/EPOA, doctor and registered nurse. Dates and times are also recorded in each of the six examples viewed.</p> <p>There is a policy on interpreter services that informs about options available to the service to ensure the language needs of all residents are met. The facility and quality managers inform that to date there has not been any requirement to access the District Health Board interpreter services. Residents' rights to interpreter services are noted in the service's information booklet.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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: Not Audited
Evidence:

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

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited

Evidence:

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

Consumers have access to visitors of their choice.

Attainment and Risk: Not Audited

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: Not Audited

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:

Six of six staff interviewed are aware of the complaints process and inform that information on advocacy services is on the wall of the lounge area (sighted). A complaints policy and procedure and flowchart (current) is sighted as is a complaints register for 2013. The latter notes the nature of the complaint, the name of the complainant, the date the complaint was received, the date the complaint was acknowledged in writing, the date the corrective action plan commenced, the date and sign off for when the corrective action was completed and the name of the person assigned responsibility for implementing and closing the corrective action. A complaints folder holds the register, which has three complaints registered in it. On investigation, one was transferred to the incident reporting system. All complaints are reportedly taken seriously and copies of all related correspondence are held in the complaints folder. The complaints form includes a section for corrective action follow-up and communication with the complainant. These are being completed. Follow-through for one complaint shows that the manager informed both the Board of Friends of Motueka Hospital Trust and the District Health Board. The complainant was offered access to an advocate and to Age Concern, a review of the person's care by other health professionals and a care plan review.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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
<p>Evidence:</p> <p>The vision statement is that the Jack Inglis Friendship Hospital facility be a leading provider of residential care for the people in Motueka and wider community. Its mission is to provide effective care and make positive and lasting differences in people’s lives through partnership with residents, family/whanau, allied health services, the wider community and committed staff. Values of the organisation are people, respect and dignity, responsible stewardship, striving for excellence, honesty, empathy, open communication and integrity and its philosophy is that people are its priority. The philosophy also notes that the care is to encompass the social, spiritual, physical, cultural and psychological characteristics of each individual. The service aims to support and assist people and endeavours to provide an environment that promotes enrichment and fulfilment through happiness and laughter.</p> <p>All of the vision, mission, values, philosophy and goals are in the Strategic Plan for 2012 to 2015, when according to the manager these were last reviewed. The Strategic Plan states its two strategic goals as ‘to enhance and sustain a range of health services relevant to being the ‘hub of health for the Motueka Community’ and ‘to create and maintain an enduring commitment to continual improvements in the quality of service and care’. Profiles of the organisation’s existing services and of its future directions are also in the plan and the latter includes an overview of factors that are influenced by population projections and the local profile; policy settings for health generally and older persons in particular and funding arrangements.</p> <p>The Strategic Plan also lists eight objectives, which in summary cover contracting and funding arrangements; the workforce; service development, relationships and infrastructure; governance and structure. It include issues about older people making decisions from options, that the quality and risk programme focuses on older people and there will be on-going reviews of it; surveys will be offered and the Board will listen to what is said; that local iwi are involved in the development of a Maori Health Plan to ensure Maori people receive good care and that nursing interventions will involve families/whanau. The manager advises that in her discussions with other providers in the district she is able to talk about the points of difference that this facility offers.</p> <p>The manager is a suitably qualified and experienced person who has been working in aged care for 20 years. She is a registered nurse with an annual practising certificate (sighted) and has been in management roles for seven and a half years, with the last four and a half being at this facility. Professional development is being maintained with attendance at leadership and marketing courses undertaken through Unitec; New Zealand Aged Care Association management workshops and</p>

conferences and at internal and external training sessions on clinical topics, such as syringe drivers and medication management. In addition she attends the Health of Older Persons Continuum meetings with the local District Health Board and is on the Nursing Advisory Committee for the Nelson Marlborough Institute of Technology. The manager informs she has recently resigned from her position and this takes effect from 27 December 2013. Her position is due to be advertised and the Board are currently in the process of advising the Ministry of Health. A part time quality manager, a clinical manager and a charge nurse are part of the manager's support team.

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: There is a quality and risk management plan 2012 – 2014 (sighted), which includes an organisational chart and links to the Strategic Plan and includes a Quality philosophy statement. A quality manager, who is also a registered nurse, is employed by the organisation. The facility manager provides reports on behalf of the quality manager to the Board of trustees every twelve months. A copy of the latest report is sighted and includes a summarised response of how each goal in the strategic plan is being met. The four specific quality goals are 'to continuously improve the safety of services; to continuously improve our systems and processes; to continuously improve our practices and to continuously improve our relationships and partnerships'. The quality and risk management plan has a table, which indicates the frequency of review, shows the status of each goal and the level of achievement for each. Each goal has a set of quality indicators and methods for measurement of each quality

indicator. Service providers are updated on the quality and risk system at the monthly quality assurance/staff meetings and six of six caregivers confirm their familiarity during interview. All heads of department, or specialist roles, for example infection control co-coordinator, restraint coordinator, diversional therapist, kitchen, laundry housekeeping and maintenance representatives, the clinical manager, the charge nurse, the quality manager/health and safety officer and the facility manager/manager are required to attend. If unable to do so they must present a report against a set of objectives from their area to the quality manager prior to the meeting. Other staff are invited and encouraged to attend and there is a good cross-section of staff attending as internal training is added to the end of the meeting.

There are ten operational manuals containing policies and procedures for food services, laundry services, maintenance services, diversional therapy, cleaning services, administration/reception, care management, infection control, health and safety and fire evacuation. These are updated according to a policy review system that is described in a document control policy and procedure. The quality manager has a set of policies to be reviewed as part of a monthly quality related workload record, which informs what is due for review, internal audit or evaluation each month. The date of review is recorded on the footer of the document if a change is made; otherwise the date of review is recorded on the master index at the front of the manual. This front page shows when the full manual has been reviewed, or the status of review of a specific document. An electronic archived copy of the document is also retained. There is a folder distribution list that informs what manuals are where and which contain copies of forms. All new documents require the manager's approval.

The staff/quality meeting agenda is sighted and includes: welcome, apologies, minutes of last meeting, matters arising, health and safety report /adverse/ events/incident report/hazard report, IC, restraint, quality improvement, department reports, general business. Quality meeting minutes for 1 August 2013, 6 September 2013 and 3 October 2013 are also sighted and each set reports against the standard agenda. All key components of the quality system are included. Annual (and as needed) health and safety meetings are occurring as part of staff meetings and minutes (October 2013 meeting) show items such as the currency of the hazard register and reports on the collation and analysis of data from adverse event reporting are presented. The service has tertiary accreditation from the Accident Compensation Corporation (certificate sighted).

Specific quality improvement projects are reportedly the development of the training recall process, streamlining new staff orientation for the different disciplines, the ACC self-audit and introduction of the new medication charts. Evidence of these is sighted during the audit.

A report from the collation of information from the staff survey is dated August 2013 (sighted). Also sighted results of a palliative care survey that was sent to family members with all responses scoring 100%. The resident/whanau survey was undertaken in April 2013. Discussions with kitchen staff regarding feedback on food reportedly occurred.

Corrective actions are an integral part of the quality and risk system in this organisation. There is a form used for this purpose and review and evaluation processes are occurring in the form of re-audits, survey questions and visual inspections. All corrective actions have plans developed for them and are followed up with the date of closure recorded and a signature of the person responsible for following it up.

A risk management procedure notes that the Board of Directors and management ensure significant risks are identified, managed and/or prevented. Levels of risk are categorised as minor, moderate, significant, severe, extreme and catastrophic and categories of risk in the risk management plan are financial, property and equipment, employee, resident care/consumer related, governance/management and physical. The plan is reviewed fully every year, although modifications are made as a result of quality meeting discussions when issues arise.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>The facility manager provides examples of the service's obligations in relation to essential notification reporting. Examples include that police, the coroner and the District Health Board (DHB) portfolio manager are to be informed should a sentinel event such as an unexpected death occur. The DHB, the Ministry of Health (MoH) and police are to be informed if controlled medicines go missing, the DHB is to be informed if they are unable to engage sufficient staff, or there is inadequate registered nurse cover, the DHB and the MoH are informed when there are plans to reconfigure services, increase capacity or change the manager. Performance monitoring reports are to be presented as and when requested.</p> <p>Adverse, unplanned or untoward events are documented on incident reporting forms, as per the organisation's policies and procedures on the topic. Data from these reports is collated and presented to the quality/staff meeting by the quality manager as part of the health and safety report (sighted). Also sighted three sets of minutes of the monthly staff/quality meetings and note that changes have been made to details about service delivery for individuals. For example a person who featured as having had multiple falls was issued with a higher walking frame and different footwear.</p> <p>The six month collation of data for adverse events October 2012 to March 2013, which is also detailed in a pie graph, identified a set of patterns around falls and skin tears in particular and these have been addressed at the clinical level. The report breaks down skin tears and falls into sub-categories to aid analysis. A list of corrective actions that were implemented, such as education as a result of medication errors the re-positioning of beds and reminders to use call bells to reduce the likelihood of residents falling and the management of behaviour incidents are in the report. The quality manager is currently developing the March 2013 to October 2013 report and</p>

informs that this will inform whether the interventions taken have contributed to any reduction in previous types of incidents.

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:

A register of annual practising certificates that lists registered nurses, general practitioners, the podiatrist, the physiotherapist, enrolled nurses and the pharmacist is sighted. A copy of the most current annual practising certificate is retained on file. Checks of practising certificates are part of the monthly quality check system undertaken by quality manager.

The manager describes the process for appointing new staff and the recruitment policy includes an employment process flowchart. If multiple responses are received for a position a short list is developed prior to interviewing. Police and reference checks are undertaken and copies of these are in nine of nine staff files viewed, as is evidence of application forms, responses to initial interview questions, position descriptions, copies of individual employment contracts and copies of performance appraisals for monitoring. A performance appraisal is undertaken three months after commencing employment and annually thereafter. The facility manager, quality manager, clinical manager or senior registered nurse is responsible for these. Records of these are included in a staff appraisal register. There are disciplinary processes in place for use in times of inadequate performance or misconduct and the facility manager describes an example of the dismissal of a staff person following the investigation of a complaint from both a resident and a staff person.

Records of staff having completed and signed off their orientation programme are in eight of nine staff files. The ninth is for a long serving staff person who was employed prior to the filed checklists sighted. A review of the organisation's orientation programme is an example of a continuous quality improvement programme that was developed following the organisation self-identifying the need to streamline and improve it. When staff commence with the service they receive an orientation handbook that covers facility information, the service philosophy, training and appraisal details and information on the quality system, health and safety, sick leave, communication and time sheets for example. Also included are copies of key policies related to the Code, such as abuse and neglect, acceptance of gifts and standards precautions and caregivers receive a copy of the restraint minimisation training manual. All new staff are given a general induction checklist and checklist sheet as well as a set of additional competencies specific to their role e.g. for caregivers, enrolled nurse, registered nurses, laundry/housekeeping/maintenance and for kitchen staff (sighted). New staff have three months to complete the checklist. Caregivers are usually buddied with an enrolled nurse for two morning and two afternoon shifts, although the buddy system is reportedly individualised for all new employees. Staff also report during interview that orientations in this facility are thorough. A master orientation folder includes information and copies of presentations and hand-outs of the topics provided on orientation days, which staff attend one of within their first six months of employment.

A current training schedule is sighted and includes core training days. Examples of internal training provided during 2013 are complaints, security, cultural safety, health and safety, civil defence and emergency and infection control. Core training requirements are on a spread sheet that lists staff names and shows the date of the latest attendance at each core training topic. Core competencies that are due for specific staff also feature in the monthly quality checks undertaken by the quality manager. For example there is evidence that all 14 registered nurses have an up to date medication competency as do 25 senior caregivers and three enrolled nurses. Other examples sighted are the topical medication competencies that are required of all staff who apply creams or eye drops for example, even if they do not administer medications; restraint; chemical safety; chemical spill kit; hoist use, male and supra-public catheterisation, safe food handling, suppository administration for enrolled nurses and there is a syringe driver register. Some topics are for specific staff groups. The clinical manager and/or a district nurse oversee other nurses who may assist with competency assessments. All training and competencies are flagged on the spread sheet and a registered nurse follows up any staff person who has an outstanding core competency. The reviewed and amended system to identify and record on-going staff training and competencies has fulfilled the required improvement identified at the last audit.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:
<p>A recently reviewed policy and procedure on staff rostering and skill mix is sighted. The manager informs that the two weekly rosters are based on recommendations in the Ministry of Health safe staffing guidelines ‘Indicators for Safe Care and Dementia Care for Consumers’ and that rosters are reviewed daily against occupation and acuity, for example, to ensure residents’ needs are met safely.</p> <p>Three weeks of rosters are reviewed. As informed by the facility manager, there is evidence a registered nurse is on duty 24 hours on seven days of the week. The registered nurse(s) is/are available to the rest home and dementia service when required. Shifts are mostly of seven, or seven and a half hours, although some evening ones are only five hours in order to cover the busy times. The length of shifts allow for handovers between shifts. A facility manager works full time Monday to Friday and is assisted by a part-time quality manager, who is also responsible for health and safety and staff training.</p> <p>Hospital area: A clinical manager and a registered nurse are on duty in the morning with an enrolled nurse or senior caregiver, plus three other caregivers. A registered nurse and three caregivers cover the afternoon shift and a registered nurse and a caregiver cover the night shift.</p> <p>Rest home area: A Charge Nurse is rostered on the morning shift (Monday to Friday) with three caregivers. The afternoon shift has two caregivers on duty and the night shift has one.</p>

Dementia service: Two caregivers cover the morning shift and two in the afternoon with one on at night.

In addition, a maintenance person and gardener both work five days a week. There is one cook and three kitchen hands on duty in the kitchen each morning and one kitchen had in the afternoon. There are also two cleaners and one laundry assistant each day. Two diversional therapists cover 57.5 hours a week spread across all three types of service.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:

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

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:

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

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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; D16.5c; 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:

Care is provided by a team of staff which include Registered Nurses, Health Care Assistants, Diversional Therapist, Activities Staff, and General Practitioners, with support provided by a Quality Manager and Manager. Allied health staff are available and include physiotherapist, podiatrist, district nurses and specialist nurses when required. Care is provided within a multidisciplinary team framework and is inclusive of the resident and family members when appropriate. Communication processes are well embedded and support the provision of appropriate care in a timely manner.

Four of four dementia, five of five rest home and five of five hospital resident files reviewed demonstrate that on admission, residents are assessed by an RN using a tool that collects information on communication, mental status, mobility, bathing and grooming, sleep, pain, breathing, sexuality, nutrition, skin integrity, elimination, rehabilitation needs, restraint, challenging behaviour, spiritual and cultural needs. Lifestyle plans are developed based on the assessment and identify individual goals for the resident. There is evidence that the lifestyle plan is developed by the primary nurse with the resident, and family members, and these plans and associated assessments are routinely reviewed 6 monthly in all 14 files reviewed.

Assessment tools are available and utilised when appropriate and include Pain Assessment, Elimination/Continence Assessment, Braden Pressure Area Assessment, Falls Risk, Wound Assessment, Nutritional Assessment, Behaviour Assessment. Residents have regular access to their identified GP, a contracted physiotherapist and podiatrist. A comprehensive activities plan is available in all areas with residents reporting they are able to participate as they wish without pressure from the staff. Diversional therapy (DT) profiles and activities plans are individualised to the resident and evident in all residents files reviewed (total 14). The DT and activities staff confirmed that assessment process help support the development of an activities programme that reflects the needs and goals of the residents.

Five of five hospital and five of five rest home residents' files demonstrate that care is evaluated daily and documented in progress notes, with four of four dementia resident files documenting at end of each shift, as per the facilities policy. Where there is a change in the health status of the resident, the GP is contacted and a visit is arranged either that same day or next day depending on the acuity. Two Clinical Managers and one RN confirmed there is a good relationship with the local GPs who provide care and this occurs in a timely manner. They confirmed that the GPs routinely review residents three monthly, with acute episodes well managed, including after hours. Two of two residents confirmed that they see the GP regularly and they can see him at any time. They reported that the staff call the GP when they are unwell or when they hurt themselves. One GP confirmed that they provide care routinely as part of the review process, as well as in response to a request from nursing staff. The GP's also provide a duty after hour's service.

Four of four family members confirmed their satisfaction with the facility, the staff and the care provided, and felt that the communication between the staff, family and residents was very inclusive and they feel welcomed into the facility at any time. The staff are responsive to questions and ensure that acute episodes are well managed. Two residents confirmed that the staff are respectful, maintain privacy at all times, and provide good care in response to their needs.

Tracer 1 Rest Home

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

Tracer 2 – Hospital

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

Tracer 3 – Dementia

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
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: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Assessment processes are commenced on admission and include an assessment of activities of daily living, communication needs, mental status, mobility, sleep, pain, sexuality, breathing, nutrition, skin integrity, elimination, rehabilitation needs, restraint, challenging behaviour, spiritual and cultural. Information collected from the nursing assessment informs the development of a lifestyle plan with identified individual goals and appropriate interventions. A Diversional Therapy Residents profile is developed and contributes to the development of an activities plan for the resident. Nutritional assessments reflect the nutritional needs of the resident and identify any interventions that may be required. The lifestyle plan, nutritional profile and diversional therapy plan are developed in collaboration with the resident and their family, with evidence in 14 resident files reviewed. Four family members confirmed they are supported to be involved in care planning and are informed of any events that impact on the health status and general wellbeing of the resident. One RN and two Clinical Managers confirmed that the primary nurse is responsible for the completion of assessments, and the development and evaluation of care plans, with six monthly reviews undertaken routinely.

Assessment processes are supported by specific risk assessments which are utilised when indicated and identify risks that are specific to the resident, such as falls and pressure areas. Short term care plans are developed in response to residents needs such as plans to manage wounds, continence, challenging behaviour. Five of five rest home, five of five hospital and four of four dementia resident files demonstrate that all assessments (including risk assessments) are completed on admission and evaluated 6 monthly routinely. Progress notes demonstrate care is responsive to the needs of the resident. Two of two residents confirmed that the care provided meets their needs with staff responsive to any changes in their needs and health status.

All 14 charts reviewed demonstrate regular three monthly review by the nominated GP, with regular reviews for acute episodes.

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 entry to the service, a resident profile is created by the Diversional Therapist (DT) and nursing assessments identify the level of independence with activities of daily prior to admission. Documentation was sighted in four of four dementia, five of five rest home, and five of five hospital resident charts, with evidence of six monthly review and evaluation occurring.

Residents have access to a range of activities that are provided Monday to Friday by the DT, supported by two DT assistants and volunteers. Activities include house, crafts, music, bus outings, cards, chair exercises, and newspaper reading. On the day of audit, school children visited to sing to the residents in all wings, and chair exercise was occurring in the Rest Home. Activities are provided in communal areas and provide the resident with the option of joining in or not. Two residents confirmed that they were able to choose what to get involved with and this was checked prior to each activity. A monthly calendar is sighted in a resident's room. Four family members confirmed that there was a big variety of activities available, including the support for residents to go out on leave.

The DT confirmed that participation was assessed and recorded daily, and where it was noted that a resident was not engaging, individualised plans were discussed with the resident and or family as appropriate to see if other steps could be taken to provide access to activities. Where possible, one to one attention was provided to support participation.

Components of the Eden Philosophy and Spark of Life are incorporated into activity planning and provide opportunities for participation in meaningful activities for all residents. The facility has a cat, a bird, goldfish and chickens, with access to outdoor facilities, which are secure in the dementia unit.

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:

Five of five hospital, five of five rest home and four of four dementia resident files demonstrate that risk assessments are completed on admission and reviewed as part of the formalised six monthly review process led by the primary nurse. The six month review process includes the lifestyle plan and achievement of documented resident goals. The DT activities plan is reviewed every six months, with a document that captures daily participation in activities which is used to ensure the plan reflects the needs of the resident and were evident in all 14 resident files reviewed. Four of four dementia resident files demonstrate that behaviour plans have been developed and document the behaviour and the effectiveness of the interventions, with modifications as required.

Where progress is different than expected or an acute illness or injury is sustained, the lifestyle plan is altered to reflect the changes, or a short term care plan is developed, as was evidenced in the three tracer files reviewed. Short term care plans were sighted for the management of wounds, acute illness, management of herpes zoster, strategies to reduce falls, and continence. Short term care plans sighted demonstrated that evaluations occurred as per the timeframes stipulated in the care plans.

Progress notes of 14 resident files reviewed demonstrate regular reporting of the health status of the resident and episodes which are of an acute nature, with GP review organised in a timely manner and reflective of the acuity of the resident. The GP confirmed that the six residents she was responsible for were reviewed routinely three monthly and nursing staff were in frequent contact with her and her colleagues when the resident required additional review of discussion of care and progress. Two Clinical Managers, one RN and two HCA's confirmed that GPs were available when required. The HCA's confirmed their role in ensuring the RN was made aware of any episodes that required review.

Four of four relatives interviewed confirmed that they were involved in the care planning process including the six monthly reviews. They were encouraged to attend the three monthly GP reviews when required, and had good communication channels with the facility staff at any time. The relatives confirmed that there was a feeling that the care provided was responsive to the needs of the resident, and staff were supportive of their feedback and any suggestions that they had about the care to be provided. Communication forms in all 14 resident files documented communication that was initiated by the staff as well as by family members. Instructions are sighted in all files reviewed of who to contact when required and the preferences for contact such as at any time, or depending on the health status of the resident.

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: Not Audited

Evidence:

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: Not Audited

Evidence:

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

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA

Evidence:

There are policies and procedures in place to support a medication management system that meets legislative requirements and safe practice guidelines. Medications are provided from the pharmacy in individualised blister packs. On receipt of the packs a medication reconciliation process occurs to ensure that the medication matches the prescription and left over medications are returned to the pharmacy. Improvements have been made to the medication chart which has seen the introduction of a PRN medication recording chart that requires the documentation of the indications for use and maximum doses to be administered. Four of four dementia, five of five rest home and five of five hospital resident medication charts demonstrate that all medications are appropriately charted, discontinued medications are signed and dated, allergy status is recorded, and indication for use and maximum doses are recorded for all PRN medications. Specimen signatures are evident in the folders containing all the medication charts in all three areas of the facility.

Controlled drugs are separately blister packed, stored within a locked controlled drug cupboard, and recorded in a designated controlled drug book. Weekly stock checks and six monthly quantitative stock checks are occurring for general stock controlled drugs as well as those contained in the blister packs. One RN and Manager confirmed their understanding of the process for controlled drugs and described the improvements implemented as a consequence of corrective actions at the previous audit.

A medication round is observed, with the RN demonstrating compliance with the administration process, including confirming the contents of the blister pack alongside the prescription. Residents are observed to ensure that medication is consumed, with individual needs for administration observed. The RN was observed to provide an explanation to a resident with regard to the medication they were taking. One rest home resident is responsible for the self-administering of his inhaler medications. There is evidence that the competence to self-administer has been assessed and reassessed during GP reviews.

The RN and two Clinical Managers confirmed that all RN staff have completed the medication competence assessment process alongside the enrolled nurses and those senior caregivers who have responsibility for administering medications, which includes a specific package for topical medications. Competence records were sighted. The Facility Manager confirmed that there is a requirement for RNs to complete further medication competencies as a component of their professional development external to the facility. This can include short courses that may be provided by learning institutions with an example provide of syringe driver education via the local Hospice.

Corrective actions from the previous audit – 1.3.12.1; 1.3.12.3 and 1.3.12.6 have all been addressed.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: <p>Four of four dementia, five of five hospital and five of five rest home resident files demonstrate that nutritional assessments are completed by the RN on admission to the service and reviewed monthly or in response to a clinical need. Nutritional likes and dislikes are documented, as are the requirements for individualised diets. The Cook confirmed that where specific needs are required, this information is provided to the kitchen and kept with nutritional profiles for all residents which were sighted. There is evidence in five resident records of requests for modifications to diets that have been made to the kitchen as well as evidence in the resident's nutritional profile information held by the kitchen. The Cook confirmed that special diets included modified texture, diabetic, vegetarian, low fibre/residue, low fat, as well as modifications to the menu to suit the needs of a resident identifying as Asian. Sandwiches are available to residents for morning and afternoon tea.</p> <p>Documentation demonstrates that the menu has been reviewed by a contracted dietitian, who also provides advice as required. The menu is based on a four week cycle, with a summer and winter menu. The RN staff are responsible for the organisation of any supplements that may require special authority following the appropriate assessment.</p> <p>The kitchen is on-site but in a separate building, with meals delivered to the dining areas in a Bain Marie. Meals are served by kitchen staff, with feeding support provided by care givers and in some cases family members or volunteers. The kitchen was refurbished in July 2013 which included painting, rearrangement of food storage areas, new equipment, new stainless steel work surfaces, new flooring and complies with infection control practices and safe food handling guidelines and closes off the corrective action from the previous audit. All kitchen staff have completed safe food handling training, with policies and procedures in place to support adherence to the appropriate food standards.</p> <p>Documents provide evidence that refrigerator and freezer temperatures are monitored and recorded daily, with food temperatures monitored weekly. Food is stored off the floor with food observed to be within expiry dates. Some 'left overs' are kept in the fridge, with food well sealed and labelled with a stickers to ensure food is not kept for more than 24 hours.</p>

Each of the three areas within the facility have access to a tea and coffee making area and cold fluids. Residents are provided with fluids during breakfast, morning tea, lunch, afternoon tea, dinner, and supper, with fluids also observed to be in reach of the resident when in their rooms. Two clinical managers confirmed that the kitchen staff were responsive to the needs communicated to them and that resident's needs were able to accommodate at short notice.

Four residents confirmed that they enjoyed the food they received; the meals were hot and were of a size that met their needs. Four relatives indicated that their family member was happy with the food provided and that they had no complaints about the food received.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:

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

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: A building warrant of fitness issued 29 September 2013 is dated 24 September 2013. The certificate of compliance with inspection, maintenance, and reporting procedures is dated 27 September 2013 and addresses an area for improvement raised at the verification audit for the new rest home wing.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
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: Not Audited

Evidence:

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: Not Audited

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: An updated evacuation plan that covers the new wing is sighted. This is dated 8 March 2013 and addresses an area for improvement raised against criterion 1.4.7.3 at the verification audit in October 2012. Records of fire evacuations, as required under the approval, are also sighted.

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: Not Audited
Evidence:
Finding:
Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Organisational restraint minimisation and safe practice policies and procedures include definitions of different types of restraint and of enablers. During interview, six of six staff report an awareness of the differences between a restraint and an enabler. They are familiar with the concept that people can decide for themselves, or agree, that they will use an enabler for their personal physical safety.

The restraint register shows three enablers and eight restraints are currently in use in this facility with soft lap belts, bed rails and a locked tray table being the devices in use. Monitoring forms are used on each shift and a sample of completed copies demonstrates these are being consistently completed. Residents and family members are consulted when an enabler or a restraint is to be used and the GP is involved in their approval and in three monthly review processes. A six monthly internal review of restraint and enabler use is scheduled for the upcoming quality/staff meeting in November. The restraint coordinator and the manager both inform that restraints are used as a last resort, but will be considered if a person's safety is compromised.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;

- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited

Evidence:

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

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

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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: Not Audited
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: Not Audited
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: Not Audited
Evidence:

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

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: At the beginning of every month the infection control (IC) coordinator collates all information about residents' infections. The IC coordinator is aware of most infections because of her role as registered nurse/clinical coordinator, however she informs she works through the medication charts and progress notes to ensure the records are

complete. The data is separated off for each of the rest home, hospital and dementia services. Policies and procedures detail surveillance requirements and list and describe the conditions for the following infections that are included in the data: urinary tract infections (UTIs), chest infections, influenza, eye, skin or wound, gastrointestinal, and other (eg, fungal). The data is plotted into a graph that is presented with a verbal report at the next quality/staff meeting and the graph is also displayed in the staff room. The IC coordinator informs (confirmed by the manager and the staff during interview) that 10 to 15 minute education sessions on infection control are provided to staff in the quality meetings. These reportedly focus on prevention and standard precautions, especially hand washing. Infection rates are low with only one UTI, two respiratory and two skin/wound in two different areas for the most recent record. The Board of Directors receive a copy of quality/staff meeting minutes every month in addition to manager's report, both of which include infection surveillance reports.

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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

