

Awanui Rest Home Limited

Current Status: 8 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

Awanui Rest Home is certified to provide dementia level care with a total of 23 residents occupying 23 available beds on the day of the audit.

Family members interviewed spoke highly of the service. The quality and risk management programme is implemented with management of complaints, incidents and accidents, monitoring of infections, implementation of an internal audit schedule and surveillance of infections. The manager is on site with staff that is trained in dementia care and there is a full time registered nurse.

The improvement required at the certification audit around doctors signing for individual prescriptions has been addressed.

Improvements are required to wound documentation and aspects of care planning.

Audit Summary as at 8 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 8 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 8 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 8 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Safe and Appropriate Environment as at 8 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 8 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 8 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 3.91)

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:	Awanui Rest Home		
Certificate name:	Awanui Rest Home		
Designated Auditing Agency:	HDANZ		
Types of audit:	Surveillance		
Premises audited:	454 Panama Road, Mt Wellington, Auckland		
Services audited:	Dementia		
Dates of audit:	Start date: 8 November 2013	End date: 8 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:			23

Audit Team

Lead Auditor	XXXXX	Hours on site	10	Hours off site	8
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	10	Total audit hours off site	9	Total audit hours	19
Number of residents interviewed	4	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents' records reviewed	3	Number of staff records reviewed	4	Total number of managers (headcount)	1
Number of medication records reviewed	11	Total number of staff (headcount)	21	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	11			Number of GPs interviewed	1

Declaration

I, XXXXX, 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 has finished editing the document.	Yes

Dated Wednesday, 18 December 2013

Executive Summary of Audit

General Overview

Awanui Rest Home is certified to provide dementia level care with a total of 24 residents occupying 23 available beds on the day of the audit. Family members interviewed spoke highly of the service. The quality and risk management programme is implemented with management of complaints, incidents and accidents, monitoring of infections, implementation of an internal audit schedule and surveillance of infections. The manager is on site with staff that are trained in dementia care and there is a full time registered nurse. The improvement required at the certification audit around doctors signing for individual prescriptions has been addressed. Improvements are required to the following: fridge temperatures, documentation of wound assessments and plans, completion of reassessments and evidence that all aspects of the care plan have been reviewed in a timely manner.

Outcome 1.1: Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. An interpreter's policy is in place and external assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process and the complaints register is up to date with evidence of timely resolution of complaints.

Outcome 1.2: Organisational Management

Awanui Rest Home has a quality and risk management system implemented. Key aspects of the quality improvement and risk management programme include monitoring of incidents and accidents, health and safety, implementation of an internal audit schedule and surveillance of infections. The service has policies and procedures that are reviewed annually. The service has human resources procedures for staff recruitment and employment and there is an implemented orientation programme and annual training schedule that is implemented. Staffing levels safely meet the needs of the residents.

Outcome 1.3: Continuum of Service Delivery

The service has a documented assessment process and there is an information pack available for residents/families at entry. Care plans are individualised and evaluated six monthly. The service facilitates access to other medical and non-medical services. The diversional therapist and all staff provide a varied activity programme with residents actively engaged at all times. The medication management system is well implemented. Meals are prepared on site by the cook and individual and special dietary needs are catered for. Residents and family interviewed responded favourably to the food that was provided. The improvement required at the certification audit around doctors signing for individual prescriptions has been addressed. Improvements are required to the following: fridge temperatures, documentation of wound assessments and plans, completion of reassessments and evidence that all aspects of the care plan have been reviewed in a timely manner.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness. The facility is maintained by the owner with contractors used when required. There is a refurbishment programme in place. There is a safe and secure external area for residents to access. The external and internal environment is arranged with a lot of space

for walking and indoor/outdoor activities.

Outcome 2: Restraint Minimisation and Safe Practice

There are clear guidelines in policy to determine what is a restraint and what is an enabler. The process of assessment and evaluation of enabler use is the same as a restraint. There are no residents requiring the use of an enabler or restraint. Staff have had training around restraint and enablers including management of challenging behaviour and are able to apply strategies.

Outcome 3: Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service. There are audits of the environment. Infection control is linked into the quality improvement programme.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	0	0	0
Criteria	0	40	0	1	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	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	(i)A wound assessment and plan is not documented for a resident with a skin tear ii) There is limited evidence of completion of reassessments. Iii) All aspects of the care plan are not reviewed in a timely manner. Iv) The care plan is not updated to reflect the skin tear.	(i)Document a wound assessment and plan for a resident with a skin tear or wound. Ii) Complete reassessments prior to review of the care plan. Iii) Ensure that there is documented evidence that all aspects of the care plan are reviewed six monthly. Iv) Ensure that the care plan is updated as changes occur.	90

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

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

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

Attainment and Risk: FA

Evidence:

The policy on open disclosure describes requirements to share information, including adverse events, with residents and their family. Residents and their family are provided with a welcome pack at entry that includes the admission agreement, information about the service as a secure dementia unit and information about complaints and open disclosure. Contact with the family/nominated representative is recorded on the accident and incident form (sighted on 10 of 10 completed forms).

The policy on interpretation and translation services includes contact information for translation services.

There are no residents currently requiring an interpreter.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Three of three relatives report they are kept informed when their family member's health status changes.

D11.3 The information pack is available in large print and advised that this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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: Family are informed of their right to complain and the service facilitates their ability to do so. There is a clearly defined complaints procedure as part of the policy which complies with the code of rights. The policy states that all complainants will be notified within five working days on receipt of complaint, and other timeframes are in line with the Code. Three of three family members note that they were aware of the complaints process but said that they had not had the need to complain. Family interviewed confirm that they are delighted with the service provided. There have been no complaints lodged with the MoH, DHB or Health and Disability Commission as confirmed by the manager. The complaints register is available to document any complaints in if forwarded. D13.3h. A complaints procedure is provided to resident as able and to families within the information pack at entry. E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour management and encouragement for families to complain if there are any issues.

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

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): 90 <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

Evidence:

Awanui is a dementia unit of up to 24 residents with occupancy of 23. There is a manager (enrolled nurse) who is involved on a daily basis with the service. She has over 25 years' experience in aged care and is supported by a registered nurse with a current APC who has five years' experience in aged care. He also has experience in dementia care for three years.

The service has a mission and values, organisation objectives and a documented quality plan 2013. This is reviewed by the manager.

ARC E2.1 The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The key line on the website is 'at Awanui Rest Home, we don't suffer from dementia. Instead we live well with it!'

The philosophy is providing quality of life to residents by establishing routines as close as possible to those they would experience at home.

Discussion with the manager and all other staff including the registered nurse, diversional therapist and two caregivers indicates the service concentrates on engaging residents in household jobs with support for activities of daily living. Three family interviewed confirm that the philosophy is lived by the service through the passion and commitment of the manager and staff.

ARC, D17.3di The manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility for residents with dementia.

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): <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: <p>The policy manual includes a range of policies related to quality and risk management. The business plan describes quality objectives, strategies to achieve outcomes and assigned responsibility. Progress against goals is completed by the manager as part of the management and staff meeting.</p> <p>There are staff meetings in the service to review progress against the quality and risk management programme. The meetings include adverse events reported for the period, complaints, infection control, internal and external audits, family feedback, health and safety and any issues.</p> <p>The audit schedule for 2013 is followed each month and includes cleaning, medicine administration, personal care and grooming, documentation, continence, hand washing, activities, privacy, shaver cleaning, laundry, food services (sighted as completed for 2013). Corrective actions are documented on the audit forms.</p> <p>There are annual family satisfaction surveys – last collated at the end of 2012 with very positive feedback. There are also post entry satisfaction surveys six weeks after entry and the results are collated. Comments from surveys include the following; ‘amazing place’, ‘very happy with the freedom of movement for residents’, ‘couldn’t be more satisfied’, ‘well run service with dedicated staff’.</p> <p>Staff are invited to provide suggestions/feedback through the bi-monthly staff meetings and staff state that they are kept well informed about quality related activity and appreciate the range of opportunities available to contribute to discussion (confirmed during interview with two of two caregivers).</p> <p>Document control and control of documents policies guide policy/document control. A checklist documents the date of review for all policy manuals.</p> <p>Health and safety policies are implemented and monitored by through staff, management and the activities meetings. Risk management, hazard control and emergency policies/procedures are in place. Hazard identification and control is up to date with a hazard register in place.</p> <p>There are family and resident meetings held throughout the year and the diversional therapist facilitates these.</p> <p>The GP interviewed confirmed satisfaction with the service.</p> <p>There are three newsletters a year – January, mid-year and end of year.</p> <p>The service focuses on quality improvement that enhances the service for residents with dementia.</p>

The directors including the manager meet monthly to discuss any issues and review quality improvement and risk management.

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: Policies on incident reporting and accident reporting and investigation procedures describe the adverse event reporting process. Accident and incident reports are investigated by the manager and signed off as being reviewed with any actions documented. Accident and incident reports document the event, the date, those involved, the investigation, suggested and completed actions and whether the family member has been informed (sighted in 10 of 10 accident/incident reports). Accident and incident data is discussed at staff meetings. The staff meet bi-monthly and there is a monthly director meeting to review trends and discuss issues. The manager is aware of notification responsibilities and is able to describe these.

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

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

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

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

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

Attainment and Risk: FA
Evidence: There are policies on orientation, recruitment and credentialing. Job descriptions are in place and describe the position, functional relationships, primary objectives, key

tasks and expected results for each role. The registered nurse and manager have a current practising certificate - sighted. Recruitment processes are described by the manager as including an application process, interview and referee checks.

All new employees complete a documented orientation process which includes working with a support person of the same role buddying the new staff member. The orientation programme covers the essential components of the service provided including how to work with residents with dementia.

Two of two caregiver's state that they have had an appropriate recruitment, interview and employment process with an orientation completed that comprehensively covered key areas of the service. They also state that they have training monthly and all training is relevant to their roles.

The training plan is implemented with the following topics completed since January 2013; infection control, safe food handling, challenging behaviour, restraint, pain management, falls prevention, safe handling of chemicals, medication administration, continence, complaint management, sexuality and intimacy, informed consent, cultural safety. Topics related to clinical topics are facilitated by the registered nurse.

External facilitators are used when possible e.g. pharmacy.

Training records for four of four staff members indicate that they attend all programmes (compulsory training with staff rostered to attend).

All staff are trained in dementia care.

Training records are retained on individual staff files.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a service management policy and rosters sighted indicate that staff are allocated appropriately.

There are a total of 21 staff including the manager/enrolled nurse, registered nurse, diversional therapist, two cooks plus one who does cooking and laundry, maintenance three days a week, one administrator, one gardener, one cleaner, 12 caregivers.

Staffing for up to 24 residents with 23 residents on the day of audit is implemented as per the following roster:

Manager: Monday to Friday and as needed (6.30am start), registered nurse (9am-6pm five days a week), one caregiver on each wing from 6am-3pm and laundry staff who supports the caregivers in the wings in the AM. PM: two caregivers from 3pm-11pm and one from 4.30pm to 8.30pm. Night: Two staff from 11pm-7am.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Assessment, planning, evaluation, review and exit are undertaken by the registered nurse with input from the diversional therapist, manager and caregivers. Service delivery is undertaken by care giving staff, the diversional therapist, the manager and the registered nurse.

Three of three files include an initial assessment completed within 24 hours, an initial care plan completed within 48 hours and GP review within 48 hours of admission. All have a long term first developed within three weeks of admission and all have a care plan reviewed six monthly or as changes occur.

Residents and the family members interviewed indicate that they are involved in the assessment and planning process.

Residents have access to a GP with residents having a three monthly review or more frequent review as required. The registered nurse communicates well with the GP as confirmed by the GP interviewed.

Three family members interviewed report they are aware of all matters pertaining to the resident. The care plan is kept in the resident's file and made available to specialists and allied health professional.

Two caregivers and the registered nurse can describe hand over processes.

D16.2, 3, 4: The three files reviewed identified that in all files the initial assessment and plan has been dated and signed.

There is some evidence of a reassessment and the care plans are reviewed using an exception reporting approach. Note that pressure area and falls risk assessments are completed three to six monthly.

Tracer methodology

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

Improvements are required to documentation of wound assessments and plans required completion of reassessments and evidence that all aspects of the care plan have been reviewed in a timely manner.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low

Evidence:

There is reference in one file in the progress notes to dressing of a skin tear and an incident form records the initial fall and the resulting skin tear. There are templates for specialised assessments e.g. pain, continence, falls. The care plan is reviewed six monthly and documented using an exception reporting format.

Finding:

(i) A wound assessment and plan is not documented for a resident with a skin tear. ii) There is limited evidence of completion of reassessments. lii) All aspects of the care plan are not reviewed in a timely manner. Iv) The care plan for a resident is not updated to reflect the skin tear.

Corrective Action:

(i) Document a wound assessment and plan for a resident with a skin tear or wound. li) Complete reassessments prior to review of the care plan. liii) Ensure that there is documented evidence that all aspects of the care plan are reviewed six monthly. Ivi) Ensure that the care plan is updated as changes occur.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The care being provided is consistent with the needs of residents (refer 1.3.3.3) and this is evidenced by discussions with two caregivers, three relatives, the registered nurse and manager. The GP interviewed on the day of audit is complimentary of the care residents receive and states that staff inform the GP in good time of any concerns they may have regarding residents health status.

Rest home files reviewed include: possible need for a change in level of care, skin tear and falls. Interventions for UTI and strategies to manage falls are documented in the care plan and wound management is referred to in the progress notes (refer 1.3.3.3).

Second file with dementia, weight loss and some challenging behaviours. Appropriate interventions are described in the care plan and have been documented as being completed in the progress notes including monitoring weight month with a change from complan to fortisip (as per prescription) given. The resident refused to drink the powdered version and the service purchases the more expensive liquid product to support the resident. A review of the weight chart indicates that the resident has put on weight in the last month.

The third file is for a resident with constant wandering inside the secure unit with pain noted on one hand. Interventions include getting a urine sample from a urine soaked garment to give the GP direction around whether a UTI is present, giving of antibiotics as charted, monitoring of the residents wrist for swelling and pain with this documented in the progress notes and referral to the GP the following day and monthly review of weight with active encouragement of eating and drinking.

Staff including the diversional therapist and caregivers were seen to be actively engaging residents in activities during the day of the audit.

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:

D16.5d Resident files reviewed identified that the individual activity assessment is completed on entry to the service. This includes a social history. Residents are quick to engage or not engage which indicates likes and dislikes. The activity assessment (key to life) and care plan is developed with the relative whenever possible and reviewed at least six monthly. The plans are individualised and cover a 24 hour period. Three of three files reviewed include an individualised activity plan with reviews completed in a timely manner. Caregivers were observed at various times through the day diverting residents from behaviours particularly in the dementia unit. The programme observed was appropriate for older people with dementia and one to one care needs with residents actively engaged in activities including crafts, exercise, walking etc. The diversional therapist is passionate about making a difference in resident lives through activity and all staff including the manager are committed to providing activities to keep residents busy, engaged and active. The environment has been designed to create activities for people with a large outdoor area that includes gardens, edible plants, lots of areas to walk in and paths that lead back to the inside. There are safe clear windows in the fence and residents at times go and watch the motorway with the manager and diversional therapist both stating that this attracts male residents more. An attendance register is kept for each individual resident detailing their engagement in activities. Residents were observed to be really enjoying the programme and activities.

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:

D16.4a Evaluation timeframes are specified in policies and procedures. Evaluations are conducted by the registered nurse three to six monthly or when a resident's condition alters. One file reviewed had a care plan review at three monthly, one within one month and one seven months later (noting that the resident is stable). A fourth file was randomly selected to review frequency of evaluations and this file also had review of the care plan completed six monthly. Care staff monitor resident's progress on a shift-by-shift basis and report any concerns to the manager and registered nurse with progress notes recording progress.

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 1.3.12: 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:

Policies and procedures on medicine management include prescribing and dispensing, self-administration, storage and disposal, staff administration, controlled drugs, staff training and competencies and monitoring medication errors.

The medication room for controlled drugs is in a locked cupboard in a locked room. One resident using a controlled drug had this administered correctly with a weekly stocktake completed and documentation indicating that balances are correctly recorded. There is also a locked medication trolley with all other medication. The medication trolley is locked even during a medication round when the staff member giving medication moves away from the trolley.

10 of 10 medication files checked indicate that all are documented correctly in the administration records. All include photo identification and all have allergies and sensitivities recorded in the medication file and the resident file.

Medicines for residents are received from the contracted pharmacy and checked on entry to the service by the registered nurse.

Signatures of staff can be identified.

All staff responsible for medication management have completed medication competencies and records are maintained.

Six of six medication records reviewed have been reviewed three monthly and this is verified by the GP interviewed.

There are no residents self-administering medication.

Both caregivers were observed to sign for medications at the time of administering the drugs, eye drops are dated (sighted) and there is no evidence of transcribing of information.

10 of 10 files indicate that the general practitioner signs every prescription entry. The previous improvement required has been met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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>Fluids are provided with each meal, jugs of water are available in residents` rooms and morning tea, afternoon tea and supper is provided. Any dietary requirements are identified in the dietary profile, which is undertaken on admission by the registered nurse and updated as required. A copy is kept in the individual resident file and the cook has a copy. The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal. There are no special diets or residents requiring dietary supplements currently. The kitchen is clean and has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements. Food is stored safely, labelled with contents and expiry dates are monitored. There are daily temperature recordings of the freezers and chiller and food temperatures are recorded with documentation indicating that all food temperatures are in the correct range. There are some fridge recordings that are not aligned with the policy and no evidence of a corrective action to address the issue. All kitchen staff have attended food safety training and completed the necessary requirements. Three of three family members interviewed confirmed that the food meets the approval of their family member from their observation and residents appeared to enjoy the meal at lunchtime. There are no residents who are losing significant weight and the cook states that she is notified when this happens. Residents are weighed monthly whenever possible noting that at times, there are some challenging behaviours. There is an annual food service audit – last completed in February 2013. Food safety training was last provided to staff in March 2013.</p>

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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 current Building Warrant of fitness is posted in a visible location at the entrance to the facility and is current (expiry date 29/11/13). There have been no building modifications since the last audit however there have been room refurbishments.

There is a planned maintenance schedule implemented.

D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge on the day of the audit.

Interviews with two of two caregivers confirms there is adequate equipment including lifting belts.

There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.

There are safe outside areas that is easy to access for residents and family members. These include outdoor shade, tables and chairs.

The site is secure with a large gate and intercom.

There is sufficient space to allow residents to move around the facility freely.

All bedrooms have sufficient space for equipment and for staff to work. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas and throughout the facility.

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

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

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

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

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:

Policies and procedures for restraint minimisation and safe practice are fully implemented. All residents undergo a detailed risk assessment and care plans are implemented to ensure that restraint is not used. Staff are trained in the use of enablers. The policy specifies that enablers are to be used on a voluntary basis but no enablers are in use currently. Staff receive on-going education in the policy for restraint minimisation and the management of challenging behaviour with this planned for December 2013. There is no use of restraint at Awanui Rest Home.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Standard 3.5: 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:

Surveillance frequency and type is set out in policy and determined by the organisation's infections control policies and procedures that are reflective of the service offered at this rest home.

Surveillance data is undertaken as required in the Health and Disability Services Standards Infection and Prevention Control standards 2008. Infection control data is collected on site and resolution of the infection. There is monthly documentation of infections and a graph that enables trends to be analysed.

The manager and the registered nurse interviewed have a good understanding of the surveillance system and significance of collecting the data.

An antibiotic usage summary is kept up to date.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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