Presbyterian Support Central - Kilmarnock Heights

Current Status: 2 December 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Kilmarnock Heights is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 40 residents. There were 32 rest home beds occupied and including three respite care residents.

The service is managed by a manager with significant aged care management experience who is supported by a care manager who is a registered nurse (RN).

There is a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

This audit identified improvements required around pain management and aspects of medicine documentation.

The service is commended for achieving two continued improvement ratings around the activities programme and infection control surveillance.

Audit Summary as at 2 December 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 2 December 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 2 December 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 2 December 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 2 December 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 2 December 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 2 December 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.

Audit Results as at 2 December 2013

Consumer Rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on notice boards. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at Kilmarnock Heights. Complaints processes are implemented and complaints and concerns are managed. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices.

Organisational Management

Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented at Kilmarnock Heights. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings and three monthly resident meetings.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required around pain assessments. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident focused and planned around everyday activities such as gardening, baking, crafts, outings and drives.
Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around aspects of medication documentation.

All meals and baking is prepared and cooked on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. Staff are trained in food safety and hygiene.

Safe and Appropriate Environment

PSC Kilmarnock rest home facility is located on an elevated section with rural views. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is homely and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Each "neighbourhood" has a kitchenette area where residents enjoy catch up cuppas. The communal dining and lounge seating placement encourages social interaction within the rest home. Outdoor areas and the internal courtyard are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintain a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are currently no residents using enablers at Kilmarnock Heights. Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge last in November 2013.

Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (the care manager) takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information reviewed evidenced that a recent outbreak was well managed.

All surveillance activities are the responsibility of the infection control coordinators with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly. The service has earned a continuous improvement rating for their use of surveillance data to implement a project that has successfully reduced some infection rates at the facility.

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:	Presbyterian Support Central
Certificate name:	Kilmarnock Heights Home

Designated Auditing Agency:	**Health and Disability Auditing New Zealand**

Types of audit:	Certification			
Premises audited:	Kilmarnock Heights Home			
Services audited:	Rest Home			
Dates of audit:	**Start date:**	2 December 2013	**End date:**	2 December 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:	32

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	6
Other Auditors	XXXXXX	**Total hours on site**	8	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	13	Total audit hours	29

Number of residents interviewed	6	Number of staff interviewed	5	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	25	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			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	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated

Executive Summary of Audit

General Overview
Kilmarnock Heights is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 40 residents. There were 32 rest home beds occupied and including three respite care residents. The service is managed by a manager with significant aged care management experience who is supported by a care manager who is a registered nurse (RN). There is a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support. This audit identified improvements required around pain management and aspects of medicine documentation. The service is commended for achieving two continued improvement ratings around the activities programme and infection control surveillance.

Outcome 1.1: Consumer Rights
Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on notice boards. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Staff training reinforces a sound understanding of residents' rights and their ability to make choices. Support planning accommodates individual choices of residents' and/or their family/whānau. Residents and family interviewed spoke very positively about care provided at Kilmarnock Heights. Complaints processes are implemented and complaints and concerns are managed. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices.

Outcome 1.2: Organisational Management
Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented at Kilmarnock Heights. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly quality committee meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. There are also monthly staff meetings and three monthly resident meetings. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.
The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required around pain assessments. Resident files are integrated and include notes by the GP and allied health professionals.
The activity programme is resident focused and planned around everyday activities such as gardening, baking, crafts, outings and drives.
Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around aspects of medication documentation.
All meals and baking is prepared and cooked on site. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. Staff are trained in food safety and hygiene.

Outcome 1.4: Safe and Appropriate Environment

PSC Kilmarnock rest home facility is located on an elevated section with rural views. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are single, personalised and have a hand basin. The environment is homely and comfortable. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. Each "neighbourhood" has a kitchenette area where residents enjoy catch up cuppas. The communal dining and lounge seating placement encourages social interaction within the rest home. Outdoor areas and the internal courtyard are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintain a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

Outcome 2: Restraint Minimisation and Safe Practice

The service maintains a restraint free environment. There are suitable policies and procedures to follow in the event that restraint were to be needed. Resident files sampled have detailed plans around the management of behaviours that challenge. There are currently no residents using enablers at Kilmarnock Heights. Staff received training around maintaining a restraint free environment, including the management of behaviours that challenge last in November 2013.

Outcome 3: Infection Prevention and Control

The infection control policies and procedures are documented. Quality meetings are conducted monthly with infection control reports presented at each meeting and discussion occurring. Regular infection control audits and incident monitoring of infection prevention and control practices are performed and the results are communicated to staff at meetings. Staff receive training in infection control at orientation and as part of the on-going education programme. The infection control coordinator (the care manager) takes overall responsibility for ensuring that the surveillance programme is well implemented with review trends and implementation of any recommendations. The service uses an external benchmarking programme for infection control. Surveillance information

reviewed evidenced that a recent outbreak was well managed.
All surveillance activities are the responsibility of the infection control coordinators with assistance from the quality committee through the monthly quality meeting. There is an online infection register in which all infections are documented monthly. The service has earned a continuous improvement rating for their use of UTI surveillance data to implement a project that has successfully reduced UTI rates at the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	2	41	0	2	0	0	0
Criteria	2	89	0	2	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	There is no pain assessment for a resident transferred back to the service post fracture head of humerus.	Ensure pain assessments are completed for new pain episodes.	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 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.	PA Low	Three signing sheets identified administration of cough mixture and lactulose that weren't charted. There are no standing orders in place.	Ensure prn medication is prescribed before administration.	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	CI	
HDS(C)S.2008	Criterion 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.	CI	The residents were involved in the renaming of the wings in the home and chose street names. The re-named wings have become "neighbourhoods". Each neighbourhood of residents have a weekly Catch up Cuppa with the recreational officer and management. The neighbourhood groups suit residents who prefer to socialise in smaller groups. Residents participate in everyday activities such as tending to the internal courtyard gardens, feeding the resident cats, birds and fish. Residents enjoy reading to the kindergarten children during their visits. Families with young children are encouraged to visit and a children's corner has been set up. The recreational officer joins the residents for lunch sitting at a different table each time. This interaction between the recreational officer and the residents allows for more intimate discussion, suggestions and feedback on activities. Residents

Code	Name	Description	Attainment	Finding
				contribute to meaningful activities within the home. Preparations for Christmas are under way and residents are forwarding their recipes for the Christmas cake. The activity assessment plan and recreational support plan involves the resident and their family. The recreational officer gathers information including place of birth, occupation, interests and hobbies and plans individual activities for the resident around their recreational, spiritual and cultural values. Learning stories and photos have been implemented into the residents file so that staff can get to know the resident better. An example is a Maori resident of Ratana faith has a learning story in the resident file about the Ratana faith. A day trip was also arranged for the resident to see the Waka come into the harbour on Matariki day.
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	
HDS(IPC)S.2008	Criterion 3.5.7	Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. In early 2013 the service recognised that UTI numbers had increased and were above the benchmark compared to other facilities. An investigation showed some residents were not drinking sufficient fluids. Water was routinely provided to each resident on the table at lunch time. However health care assistants observed that even with encouragement residents frequently did not drink this. Residents indicated they would be more likely to drink juice so juice is now provided to all residents on the lunch table and staff report most residents drink this without prompting and those who don't are happy to drink it when prompted. To further increase fluid intake the service introduced providing ice blocks to residents on hot days. Following these initiatives the September QPS benchmarking data showed a reduction of UTI's by 60% at the facility. The care manager (the infection control coordinator) reports she has continued to monitor UTI rates closely and in August 2013 noted a slight rise. She then provided education to all residents about hand hygiene including washing hands with soap and water and using alcohol gel that is located around the facility, at the September 2013 residents meeting.

Code	Name	Description	Attainment	Finding
				Following this UTI rates have dropped again in October and November 2013.

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: FA
Evidence: The service has available information on the Code of Health and Disability Services Consumers' Rights. The Code was evident around the service. There is a resident rights policy in place. Code of Rights (CoR) training was last completed in February 2012 (this was compulsory for staff). Discussion with three health care assistants shows all were aware of the CoR and could describe the key principles. Staff are also interviewed as part of the client rights audit.

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

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

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA
Evidence: Resident's rights information is available, and a large poster is framed on the walls. The code of rights and advocacy pamphlets are located at the main foyer. D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet, advocacy and H&D Commission information. Service information provided to residents and/or their families/whanau prior to entry and some of this documentation is in larger print format. The interpreter service information is also available in the resident orientation pack. The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents, such as on tape and video. Staff will read information to residents and explain it (e.g. informed consent and CoR). Information is also given to next of kin or EPOA to read to or with the resident and discuss in private. On entry to the service, the manager or care manager discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Six residents stated they were well informed about the CoR and the service provides an open-door policy for concerns/complaints. Information on complaints and compliments includes information on advocacy.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records and employment agreements bind staff to retaining confidentiality of client records. There is a comprehensive resident records policy that includes; a) integrated resident records, b) information requirements, and c) integrity of computerised records. Discussions with six residents and three family members identified that personal belongings are not used as communal property. The staff were respectful of entering a resident's room and gained permission before doing so. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. D4.1a : The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. The support plan includes a 'spirituality, faith and culture' section and this was comprehensively completed in six of six resident files sampled. D5.4p There is a sexuality and intimacy policy. The service includes within its care planning assessment and directions for emotional wellbeing and this includes sexuality and intimacy. Discussions with six residents and three family members confirmed that residents are able to choose to engage in activities, access community resources

and so on. Residents and family members confirmed that they believe that have adequate rights to choose within the constraints of the operations (e.g., meal times) of the service and that staff are very obliging around choice.
Discussion with three health care assistants could describe examples of giving residents choice including, what time they would like to get up, choices on food, and what they would like to wear.
The service implements the Eden Philosophy and staff could describe a more resident-focused care instead of task orientated.
There is an elder abuse and neglect policy and abuse or neglect reporting process. Elder abuse and neglect training is compulsory annually and was last completed in September/October 2013 as part of the health care assistant study days. Discussions with management (the quality coordinator, the care manager and the facility manager) and staff (three caregivers and the recreation officer) identified that there were no incidents of abuse or neglect and that there is a culture of reporting.
Three family members and six residents were very positive about the quality of care and support provided to residents.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA
Evidence: A3.2: There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). The Presbyterian Support (PSC) wide Maori Health plan that has been reviewed and updated through the Maori Health plan Wellington Group. Cultural and spiritual practice is supported. The service has developed a link with Nga Hau E Wha Trust. The service identifies the need for staff to be trained in delivering appropriately cultural services. Cultural/treaty training has been provided as part of the Health Care Assistant study days in March and April 2013 that were attended by 19 health care assistants. There are currently two residents that identify as Maori. Their files include a specific do's and don'ts for Maori residents. The one Maori resident interviewed reports any cultural needs he has are met. One Maori resident is of Ratana faith and there is information in his file where staff have researched information about this. The three health care assistants interviewed showed a basic understanding of the Ratana faith. Discussions with staff identify that have responded appropriately to the cultural needs of residents and their whānau. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. Staff identify that they are aware of how to obtain support so that they respond appropriately.

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

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

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)
The organisation plans to ensure Māori receive services commensurate with their needs.

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)
The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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

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

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

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

Attainment and Risk: FA
Evidence: The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a spirituality, religion, faith and culture section in the care plan. D3.1g: The service provides a culturally appropriate service by identifying individual needs. The one resident who is Rarotongan has specific needs identified in the care plan and the three health care assistants are conversant with this information. D4.1c: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs. There is a chaplain who visits the service twice weekly and there is a fortnightly Presbyterian service and a fortnightly Catholic service. Discussions with six residents and three family members confirmed they were satisfied that staff considered their individual values and belief. This was also reflected in support plans.

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: There is a code of ethics policy. Job descriptions include responsibilities of the position and ethics, advocacy & legal issues. Enrolled nurse job descriptions include upholding legal and ethical standards and accountability and responsibility under the direction and supervision of registered nurses. The orientation booklet provided to staff on induction includes a section on professionalism and standards of conduct, harassment prevention policy and gifts. Understanding the code of conduct is signed as part of orientation. Completed orientation packages were sighted in five of five staff files sampled. Three caregivers and the care manager interviewed have a good understanding of professional boundaries. Six residents and three family members report that staff are always professional.

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

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

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.
The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement.
Policies and procedures cross-reference other policies and appropriate standards.
RN's are encouraged and supported to continue education. Health care assistants are supported to complete CareerForce or unit standards.
A2.2 Services are provided at Kilmarnock Heights that adhere to the death & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.
D1.3 All approved service standards are adhered to.
D17.7c.There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.
The service has implemented a number of improvements since the previous audit. These include:

- Implemented a buffet breakfast for residents. This took 1.5 years to implement starting with a roster review with staff and unions. Cook now works across both main meals and kitchen hand prepares breakfast and morning tea.
- Training has improved and Kilmarnock Heights now provides core compulsory training for Healthcare Assistants (HCA's). Staff are rostered to attend two sessions a year. These sessions are held at other homes in the Wellington region. In 2013 93% of HCA's have attended 2x 8 hour sessions.
- Kilmarnock Heights has made a significant effort to improve their medication signing sheet error rate through making changes to the format of the signing sheet, timely reminders to staff when errors occur, implementing staff resource to allow shift co-ordinators time and space to focus on the medication round uninterrupted.
- Kilmarnock Heights participated in the national drug chart trial.
- Physio students from Massey University continue to come to Kilmarnock Heights to do their placement. They work with individual residents for a period of time.
- Kilmarnock Heights have 100% of our residents taking Vitamin D supplements since August 2012; this has shown a decrease in our falls with injury.
- Environmental cleanliness audit has improved since the beginning of the year and is due in part to the work undertaken to redesign the work schedules and signing sheets.
- Recruitment of enrolled Nurses onto the PM and night shift has added another level of knowledge available on the shift. This has helped minimise the calls to the RN/care manager on call.
- Respite admissions are carefully planned and documentation is communicated to residents prior to their visit to ensure timely transition.
- Kilmarnock Heights has introduced monthly management meetings.

Organisation improvements:

- PSC has introduced a nutritionally assessed full five week vegetarian menu, which is now available with recipes.

- New food IT system that allows automatic food ordering and recipes to be printed with quantities linked to actual number of meals required. This minimises wastage from cooking too much and also ensures that there is enough food. On line recipes also allow relief cooks to have access to recipes for dishes they are unsure of. “Special week” menus and recipes are also available to substitute for the standard weeks, e.g. queen’s anniversary week menu. There are a number of ethnic recipes e.g. Indian, Chinese available.
- Cooks teleconferences started on a bi-monthly basis to review any issues around the menu, deliveries and to share ideas for resident involvement.
- Residents involved in recruitment of new staff.
- Clinical nurse specialist available to work with registered nurses who require additional support.
- Relatives and friends information booklet printed.
- Admission agreement reviewed and simplified so that residents and families can follow it.
- On line incident, medication error, and infection register with associated user manual. Able to generate reports for trend analysis and concerns with individual residents.
- Annual chaplaincy peer supports commenced.
- Enabler and Infection Control Coordinator Days now occur.
- Introduction of ISBAR communication tools for RNs and care managers
- Development of second CNS role.
- 4QL training for staff in management positions (which has been completed by the manager at Kilmarnock Heights).

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Discussions with six residents and three family members all stated they were welcomed on entry and were given time and explanation about services, procedures etc. Resident meetings occur three monthly and the manager has an open-door policy. The service has introduced a 'catch up and cuppa' where residents from individual neighbourhoods (wings) meet with the manager. This was introduced as some residents were noted not to be able to engage well in the larger residents meeting format as they have speech or hearing difficulties and every residents view is deemed important. The 'catch up and cuppa' meetings occur weekly and rotate through a different neighbourhood each week. Review of 16 incident forms from November 2013 identified that relatives are informed in all cases where appropriate. 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. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. D16.1b.ii: The 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. D16.4bThree relatives stated that they are always informed when their family members health status changes. D 13.3 Six files reviewed included completed admission agreements. The admission agreement contains schedule 2 fees and charges. Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry. The admission agreement has recently been reviewed at an organisational level to make it more user friendly for residents and families. D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence:
Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Residents' Rights training was last provided February 2012. Interviews with six healthcare assistants identify that consents are sought in the delivery of personal cares and this is confirmed by six residents interviewed. A sample of six resident files all included signed consent forms for storage of personal information; to deliver care and support based on assessed needs; to take photograph for the purpose of health information; to have care delivered by supervised students; to be transported on outings; to involve family/whanau in assessment, planning and delivery of care. There is a resuscitation consent policy and a resuscitation consent form. Residents who are deemed competent to sign a resuscitation decision form indicate whether or not they wish to be resuscitated. A sample of six resident files identified resuscitation consent forms were completed as appropriate. D13.1: there were six admission agreements sighted and all had been signed on the day of admission. D3.1.d: Discussion with three family identified that the service actively involves them in decisions that affect their relative's lives.

Six rest home residents interviewed confirmed they were consulted and given information to enable them to make informed decision regarding their care.

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

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

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

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

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

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)
Advance directives that are made available to service providers are acted on where valid.

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)
Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

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

Attainment and Risk: FA
Evidence:
Client right to access advocacy and services is identified for residents and posted on the service notice-boards. The information identifies who the resident can contact to access advocacy services. Information provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Staff was very aware of the right for advocacy and how to access and provide advocate information to residents if needed. The welcome booklet includes a section around 'client advocates'. D4.1d; Discussion with three family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Family members and residents confirm that visiting can occur at any reasonable time. This is stated in the client information pack. D3.1h Discussion with six residents shows that they are encouraged to be involved with the service and care. Residents can access community services as they require. This is stated in the client information pack. Discussions with staff, residents and relatives identified that the service encourages residents to belong to community groups. There is Interaction with local school and preschools with both groups visiting often. There are community volunteers, and community groups come and entertain. D3.1.e Discussion with three caregivers, the recreation officer and the care manager and three family members indicates that residents are supported and encouraged to remain involved in the community and external groups visit.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. There is a copy of the process documented in a notice-board in the service and a complaints box at Kilmarnock Heights. Residents and family members confirmed that concerns are actioned immediately. Complaints information is included in the entry pack. There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints formal and informal are included on the complaints register and the PSC templates are used. The complaints folder and register has been kept up to date and all complaints are included on the register with evidence of follow up and resolution. There have been three complaints in 2013. One was from a family member, one from a GP of a respite resident querying charges and another from a DHB outpatient staff member unhappy a resident had not been accompanied by a Kilmarnock Heights staff member to an appointment. All have been appropriately investigated and resolved.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: Kilmarnock Heights is part of the Presbyterian Support Central organisation. The service provides rest home level care for up to 40 residents and on the day of the audit there were 32 residents. Two of these residents are under 65 years old but under the ARC contract due to being 'like in age and interest'. There were three residents on respite care at the time of the audit. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. Kilmarnock Heights has a documented mission statement, vision, values, corporate commitment and older person's services goals. There is a local risk management plan for 2013. There is an Enliven (Kilmarnock Heights) business plan that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals. The service has a robust structure that supports the continuity of management and quality of care and support (including staff management). The manager is has a post graduate certificate in business administration. She has worked for PSC for eight years in a variety of roles and has been manager at Kilmarnock Heights for 2 ½ years. She is supported by a care manager who is a registered nurse and has been in the position since March 2011. PSC provides care manager orientation training and support at least every two months across the organisation. The regional manager, Southern who covers seven PSC facilities also provides support. Enliven also provides a two day education seminar annually for all care managers to ensure that all care managers receive at least eight hours annual professional development activities related to overseeing clinical care. ARC D17.4b (rest home) The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. Since her employment the manager has completed a three day Eden training and the 4 quadrant leadership training.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: In the absence of the service manager an individual with relevant experience is delegated with the responsibility of fulfilling the manager role. The delegated person is the care manager. D19.1a; A review of the documentation, policies and procedures and discussion with staff identified that the service has operational management strategies and a quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)
During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)
The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

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

Attainment and Risk: FA

Evidence:

The service has a current business and a quality and risk management plan for 2013 to 2014. The service has continued implementing their quality and risk management system since previous certification and a number of quality improvements have occurred to address shortcomings in previous contract and certification audits.
Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and QPS benchmarking programme that is being implemented at Kilmarnock Heights. There has been a review of the Quality Monitoring Programme with new draft audit templates introduced. The new templates have been in use at Kilmarnock Heights since January 2013.
The service has a quality coordinator. The manager provides a balanced scorecard report to central office.
Kilmarnock Heights has an active combined quality committee. This committee includes key staff from all areas of the service. Quality reports are provided to the committee by members of the quality committee and include (but not limited to); a) quality coordinators report, b) kitchen monthly report, c) health & safety monthly report, d) laundry monthly report, e) IC monthly report, f) restraint monthly report, g) clinical monthly report, h) managers monthly report, i) chaplains monthly report, j) activities monthly report, k) education monthly report, l) Eden monthly report, m) domestic/cleaning monthly report and n) administrative monthly report.
The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.
The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility

and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement.
The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.
The internal audit schedule has been combined to include QMP and QPS monitoring.
Policies and procedures cross-reference other policies and appropriate standards.
There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule
D5.4: The service has policies/ procedures to support service delivery.
The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. These have been reviewed following an emergency evacuation in June 2013 when a landslide potentially threatened the home.
There is a comprehensive infection control and a restraint policy and health & safety policy/procedures.
There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance and content has been kept and sessions evaluated. Residents files are no longer relevant to the service are removed and archived in a locked cupboard.
Old policies are shredded. The service advised that records are maintained for 10 years. There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures are included in the "What's New" manual for staff.
a) Monthly accident/incident/near miss reports are completed by the health and safety officer for each site that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is an online database for recording accidents and incidents with medication errors reported separately. Incidents and accidents are also reported to PSC clinical director monthly.
b) The service has linked the complaints process with its quality management system. This occurs through the QPS benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.
c) There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed and provided to quality meeting. The service utilises the QPS benchmarking programme, which analyses service data on a quarterly basis. Infections are also being documented on the newly introduced electronic database.
QPS data analysis includes: Competency testing for infection control, wound infection rate, skin infection rate, infection rate, UTI's, respiratory tract infections, ENT rates and GI rates graphed quarterly. A benchmarking report from the three month data is prepared for staff and displayed on notice boards. Internal infection control audits are planned and undertaken during the year.
d) Health and safety monthly reports are completed for each service and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified.
e) The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Kilmarnock Heights is currently restraint free.
The service completes an internal audit for each area, which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. When a shortfall is identified a corrective action plan is developed and the area is re audited until a satisfactory result is obtained.
Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness.
The service benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

A hazard register is established for the site that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.
Civil defence procedures are in place and supported by staff training.
There is a facility risk management plan 2013 to 2014.
The service documents risk or areas of concern and remedial action is identified as a result.
D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management
D19.2g Falls prevention strategies such as sensor mats and individual review of residents who fall.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA
Evidence:
The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar

services.
Sixteen incident forms were sampled from November 2013. All show the form has been fully completed and reviewed by a registered nurse. All have on-going review and where appropriate actions to prevent recurrence completed by either the care manager or a senior registered nurse.
Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected for each site.
The monthly reports provided to staff via meetings and staff notice boards include the QPS benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The DHB and HealthCERT were informed of the landslide requiring evacuation in June 2013 and both were also informed when a resident was missing for 10 hours and the police were alerted in August 2013. The resident was found safe and well.

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: The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including registered nurses (RN)s, enrolled nurses (EN)'s, pharmacists, the dietitian, the podiatrist and GPs is kept. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one recreation officer, one cook, one enrolled nurse, one health care assistant and the care manager). Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff and records are kept. A buddy system supports new staff. There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book. There is a documented in-service programme for education. Competencies are identified and completed. Caregivers are encouraged and supported to undertake external education. CareerForce training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in CareerForce. D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for caregivers. Kilmarnock Heights has provided caregiver core compulsory training according to the framework.

Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.

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: Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements. The QPS benchmarking report for September 2013 states that staff hours remain consistently above the mean. The care manager works 40 hours per week plus on call. She is supported by registered nurses who work a further 24 hours per week. Staff interviewed including three caregivers, the recreation officer and the care manager report adequate staff cover. When a staff member is unwell the service attempts to use their own staff to cover and agency staff are used if this is not possible. Six residents and three family members report adequate staffing levels.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure office. Support plans and notes are legible and where necessary signed (and dated) by the registered nurses. Policies contain service name. Resident records reviewed contain the name of resident and the person completing the form/entry. Stamps are utilised to determine some allied staff members. D7.1 Entries are legible, dates and signed by the relevant health care assistant, enrolled nurse or registered nurse including designation. Individual resident files kept demonstrate service integration with an allied health section that contains GP notes and the allied health professionals and Specialists involved in the care of the resident. There is also an allied health services assessment form with care requirements. For the resident Interdisciplinary assessment, all team members are named on the interdisciplinary assessment form.

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

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

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Capital Coast Care Co-ordination centre (needs assessment) ensures all residents are assessed prior to entry for rest home level of care. A placement authority form is sent to the receiving facility.
The Facility Manager and Care Manager (CM) are responsible for the screening of residents to ensure entry has been approved. A pre-admission checklist ensures the potential resident and family receive a tour of the facility and are introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission.
The information pack includes all relevant aspects of service and associated information such as the H&D Code of Rights and how to access advocacy.
There is an admission procedure in place and admission documentation, which includes resident and next of kin details. The CM (interviewed) is able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission. The CM completes all the admission documentation and relevant notifications of entry to the service. Six signed admission agreements are sighted. Six residents and three relatives interviewed state they received all relevant information prior or on admission. The GP is notified of a new admission.
D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract
D14.1 exclusions from the service are included in the admission agreement.
D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement

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

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

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence:
The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. There are no declined entry records. The service has an accepting/ declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. There are no declined entry records.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: D.16.2, 3, 4: The six resident files sampled (rest home) identifies the CM or registered nurse (RN) completes an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. Six resident files sampled identified that the long-term support plan is developed within three weeks. There is documented evidence of multidisciplinary reviews (MDT) held three monthly involving the resident/family/whanau, RN and care staff, recreational officer, medical (including medication review) and where applicable allied health input. The RN amends the long term support plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist and podiatrist. All six resident files sampled included a relative contact form, which documents discussions with family/whanau regarding changes to health, incidents, infections , MDT meetings, appointments, transfers to hospital and GP visits. D16.5e: Six of six resident files sampled identified that the GP had seen the resident within two working days. It was noted in six of six resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. The GP interviewed practices with one other GP and they visit their patients each week to conduct three monthly reviews and see any residents of concern. The GPs are available after hours until 11pm and at weekends. The GP's maintain electronic records and send referrals electronically. The GP is very complimentary about the care the residents receive. There is a 15 minute verbal handover period between the caregiver shifts to ensure staff are kept informed of resident's health status and any significant

events. There is a written handover sheet with significant information recorded. The shift co-ordinator hands over to the CM/RN at 11am. This handover period is observed. Progress notes are written daily.
The podiatrist visits for four hours a month. A physiotherapist is available as required.

Tracer methodology; rest home resident
XXXXXX *This information has been deleted as it is specific to the health care of a resident*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)
Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

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

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)
Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, mobility status, equipment needs, dietary needs, activities preferences, spiritual, cultural and social needs. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment, first support plan and long term support care plan within the required timeframes. All resident files sampled evidenced an initial assessment and support care plan with reference to the information gathered on admission. Relatives and residents advised on interview that assessments were completed in the privacy of their single room. A range of assessment tools is completed on admission if applicable including (but not limited to); a) nutritional and fluid assessment, b) falls risk (adapted from Morse), c) moving and handling assessment, d) Braden pressure area risk assessment, e) continence and bowel assessment, f) pain assessment, and g) wound assessment.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops the long term support plan from information gathered over the first three weeks of admission. The resident support plan has categories of care as follows: hygiene and grooming, skin and pressure area care, elimination, mobility, nutrition and fluids, rest and sleep, communication (ability to use call bell, eyesight, memory, behaviour and mood), loneliness (companions), helplessness (socialisation), spirituality/faith and culture, medical (includes medication and pain management). Each individual page for category for care is signed and dated. There is a guide for the care of Maori residents (sighted). The integrated resident file also contains the admission documentation, informed consent forms and advance directives, care documents, risk tools and reviews, medical documents, test results (laboratory and radiology), allied health notes, referrals and other relevant information, associated assessments such as activities, physiotherapist, behavioural and other relevant information, resident recordings (weight, blood pressure, blood sugar levels, fluid balance, food charts and other interventions), incident/accident and infection events summary and correspondence. Short term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short term care plans are pre-printed for chest, urinary and ear infections, nutritional needs and wounds. Short term care plans sighted are for: nutritional needs, fracture of humerus, urinary tract infection (UTI). Medical GP notes and allied health professional progress notes are evident in the six residents integrated files sampled. Relatives interviewed are positive and complimentary about the staff, clinical and medical care provided. They confirm they are kept informed of any significant events and changes in

health status.
D16.3k, Short term care plans are in use for changes in health status. There is a short term care plan for advance care planning currently in a draft form. Advance care planning involves the GP, family and the local hospice.
D16.3f; Six out of six resident files reviewed identified that family have been involved.

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Residents' support plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The three HCA's interviewed and one CM stated that they have all the equipment referred to in support plans necessary to provide care, including hoist (checked August 2013), pressure relieving mattresses and cushions, shower chairs, transfer belts, slidy sams, chair scales (calibrated August 2013) wheelchairs, gloves, aprons and masks. The service has access to physiotherapy services for equipment assessment and trials prior to purchase.
D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. All staff report that there are adequate continence supplies and dressing supplies.
Complex or chronic wound assessment includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. Wound progress reports are in place for all wounds. A short term assessment and care plan is in place for two abrasions and two skin tears. A wound assessment and support plan is in place for an exudating leg wound. Photographs are taken as required and there is evidence of GP notification of non-healing wounds and signs of infection. The wound nurse specialist is readily available through the Capital Coast district health board. Wound management is included in the PSC study days held annually.
Continence products are available and resident files include a urinary continence assessment, bowel management, wounds and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed through the district nursing service and the continence product representative.
Behaviour management is described in the long term or short term support plan. Behaviour monitoring forms are used (sighted) which describes types of behaviour, possible triggers and interventions. The community psychogeriatric nurse for elder health will visit residents who are under the service. A health status summary held in the resident's record records any significant events, investigations, GP visits and outcomes.
An internal audit November 2013 identified deficits in pain assessment reviews. There is an improvement required in regards to pain assessments.
The physiotherapist is involved in manual handling education and resident assessments as required by referral. The podiatrist visits six weekly.

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: PA Low

Evidence:

Pain assessments are completed for on admission in six of six resident files sampled. The long term support plans include non-pharmalogical interventions. Pain relief and its effectiveness is reported in the progress notes.

Finding: There is no pain assessment for a resident transferred back to the service post fracture head of humerus.
Corrective Action: Ensure pain assessments are completed for new pain episodes.
Timeframe (days): 180 *(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: CI
Evidence: The recreational officer has seven years' experience working with PSC and has been employed full time at Kilmarnock for the last year. She is studying towards diversional therapy qualifications through career force and feels well supported by management. The recreational officer attends peer support meetings of the Wellington region recreational officers. She also attends relevant on-site education and training and holds a current first aid certificate. The programme is resident focused and is planned around everyday activities such as gardening, baking, reminiscing. Many activities are spontaneous and occur from resident suggestions. Community links are maintained with inter-home visits, attending stroke club meetings, Home of Compassion nun's visits, children's visits from the Swiss school and kindergarten. Theme days, festive occasions and cultural celebrations occur such as Easter, Christmas, Egyptian day, Matariki festival. Church services are held on site weekly. Outings and drives are arranged in consultation with the residents to places of interest. There are a number of volunteers involved in the service that provide one on one activities, musical entertainment, church visitors and SPCA visitors and pets.

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: CI
Evidence: The Eden philosophy principles of resident involvement and inclusion in their recreation activities within a home environment is evident. There is a resident voted onto the Eden Committee. The recreational support plan is individualised.
Finding: The residents were involved in the renaming of the wings in the home and chose street names. The re-named wings have become "neighbourhoods". Each neighbourhood of residents have a weekly Catch up Cuppa with the recreational officer and management. The neighbourhood groups suit residents

who prefer to socialise in smaller groups. Residents participate in everyday activities such as tending to the internal courtyard gardens, feeding the resident cats, birds and fish.
Residents enjoy reading to the kindergarten children during their visits. Families with young children are encouraged to visit and a children's corner has been set up. The recreational officer joins the residents for lunch sitting at a different table each time. This interaction between the recreational officer and the residents allows for more intimate discussion, suggestions and feedback on activities. Residents contribute to meaningful activities within the home.
Preparations for Christmas are under way and residents are forwarding their recipes for the Christmas cake.
The activity assessment plan and recreational support plan involves the resident and their family. The recreational officer gathers information including place of birth, occupation, interests and hobbies and plans individual activities for the resident around their recreational, spiritual and cultural values.
Learning stories and photos have been implemented into the residents file so that staff can get to know the resident better. An example is a Maori resident of Ratana faith has a learning story in the resident file about the Ratana faith. A day trip was also arranged for the resident to see the Waka come into the harbour on Matariki day.

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:

Three monthly MDT evaluations of the support plan are conducted and involve the GP, RN, HCA's, recreational officer, resident/family/whanau input . The written review form includes general recordings, weight and any issues to be discussed with the GP, medication chart review, medical examination conducted and GP monthly or three monthly visits indicated. The resident/family are notified of the review and invited to attend. The long term support plan is amended with each review if there are changes. The relative contact form has written evidence of discussion held with families regarding care plan reviews. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are evidenced in use. Short term support plans are reviewed regularly with problems resolved or added to the long term support plan if an on-going problem.
D16.4a Care plans are evaluated three monthly more frequently when clinically indicated
ARC D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to; psychogeriatrican, community psychiatric nurse, physiotherapist, podiatrist, General Practitioner, hospice, endocrinology, retinal screening, cardiology, orthopaedic, diabetes clinic, radiology. There is evidence of GP discussion with families regarding referrals for treatment and options of care. D16.4c; the service provided an example of a resident on respite care whose condition had changed and the resident was reassessed for rest home level of care. D 20.1 discussions with registered nurses identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist, occupational therapist and other allied health professionals.

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: The CM interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. Transfer documentation is sighted in residents record recently transferred back to the facility. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy delivers all

pharmaceuticals, monthly Douglas medico packs and prn blister packs. The returns are kept in a locked returns cupboard until collected. Regular medications are checked and signed by the CM on delivery using a medications reconciliation form (sighted). All prn medications are checked monthly. Any discrepancies are fed back to the pharmacy. The CM, enrolled nurses (EN) and senior healthcare assistants administering medications undergo a comprehensive medication competency annually and attend annual education (October 2013). Senior HCA's who administer medications are designated shift co-ordinators. EN's are employed on the afternoon and night shifts. The local hospice nurses and specialists support staff in caring for residents at end of life if requiring syringe driver medication.
The rest home medication room contains adequate supplies of pharmaceuticals, treatments, the controlled drug safe and the medication trolley. The controlled drug (CD) stock is checked and signed in the CD register weekly. There is a six monthly pharmacy audit. CD's administered are signed by two medication competent staff on the signing administration sheet. Standing orders are not used. An improvement is required in regards to the administration of prn medications.
There is one self-medicating resident. A self-medication assessment has been completed and is reviewed three monthly by the RN/GP. The resident has a signing sheet in the bedroom. The medications are kept safely in the bedroom. Eye drops are dated on opening. Medication fridge temperatures are monitored weekly and corrective actions taken as evidenced. The RN checks the oxygen and suction (serviced November 2013) weekly. A pulse oxymeter is available.
12 resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. There is a staff alert form used for changes in medication charts. Other labels used include "look for second pack", antibiotics and controlled drugs.
D16.5.e.i. 2, There is evidence of three monthly GP reviews of medications. The medication folder contains a staff and GP signing register. PRN medications are prescribed correctly with indications for use.

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: PA Low
Evidence: Prn medications are prescribed correctly with indications for use in 12 of 12 medication charts sampled. PRN medications administered record the time of administration.
Finding: Three signing sheets identified administration of cough mixture and lactulose that weren't charted. There are no standing orders in place.
Corrective Action: Ensure prn medication is prescribed before administration.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)
The facilitation of safe self-administration of medicines by consumers where appropriate.

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)
Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA

Evidence:

Food services policies and procedures manual is in place. There is a cook on duty each day from 10am to 6.30pm to prepare, cook and serve the main midday meal and tea. The morning kitchen hand prepares the breakfast and morning tea. There is an afternoon kitchen hand that assists with the tea meal and ensures the kitchen and dining room cleaning schedules are completed each day (sighted).
There is a five weekly summer and winter menu that is reviewed by the company dietitian. The company dietitian is readily available to the cook by email/phone for advice if required. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. Recipes are available on line as well as “specials” week to celebrate special events. There is a vegetarian menu available and a number of ethnic recipes if required. A buffet breakfast has been implemented and well received by the residents interviewed. The cooks receive peer support by teleconference monthly and when all the PSC cooks meet annually. All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of resident’s dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, soft or pureed meals. Specialised utensils and lip plates are available as required.
Daily food temperatures are taken on cooked food for all meals. Temperatures are taken on delivery for frozen foods, milk and cream. Fridge, freezer and chiller temperatures are recorded daily. All perishable foods are dated.
The main kitchen area is well equipped with gas hobs, electric oven, combi oven, fridge, freezers, walk in chiller, deep fryer. The equipment has all been serviced (May 2013). The dry goods are sealed, labelled and off the floor in the pantry. Goods are rotated weekly with the delivery of food orders. Chemicals are stored in a locked chemical cupboard. Safety data sheets are available and training provided as required. Personal protective equipment is readily available and staff observed to be wearing hats, aprons and gloves.
The service receives feedback directly from the residents, residents meetings, internal audits and resident satisfaction surveys. There is good communication between the food services and the clinical areas and the cooks are informed of any resident’s dietary changes. The main cook is a representative on the Quality meetings. Residents interviewed are happy with the choice and variety of meals.
D19.2 staff have been trained in safe food handling, chemical safety and other relevant in-service. The main cook is enrolled to attend Hospitality Industry courses in 2014.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. The chemicals supplies are kept in a locked area in the kitchen and locked cleaner's cupboard. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. A chemicals spills kit is readily available. Waste management contractors collect the bin weekly. Contractors remove waste from the kitchen grease trap. There is recycling of plastics, papers, tins. All infectious material is double bagged. Approved containers are used for the safe disposal of sharps. Pest control is carried out by a contracted service. Staff have attended waste management and chemical safety education. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The building holds a current building warrant of fitness, which expires 15 June 2014. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The facility is located on an elevated site with rural views. PSC Kilmarnock Heights home is a 40 bed rest home complex divided into five wings (neighbourhoods) Rata Lane, Kowhai Close, Kauri Place, Totara Tce and Rimu Glen. Each neighbourhood has its own tea/coffee making facility. The physical environment with wide corridors and spacious rooms allow easy access, movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas. There is a large communal dining, recreational room, lounge areas and smaller areas for quiet activities, private meetings with family/visitors. The maintenance person is contracted for hours eight a week to carry out minor repairs and maintenance, external building maintenance and any internal maintenance and cleaning duties as per the schedules. The FM checks the daily maintenance request and co-ordinates the repairs. The PSC property manager is available on the intranet help desk. Planned maintenance includes fire and emergency equipment checks, hot water temperature monitoring (corrective actions sighted) and equipment functional and electrical checks. There is adequate storage areas for hoist, wheelchairs, products and other equipment. The grounds are tidy, well maintained and able to be accessed safely. Ramps are in place for wheelchair access to the outdoors. There is seating and shaded areas available. There is an internal courtyard. The residents enjoy taking care of the internal gardens. Residing cats, birds and fish add to the home like environment for the residents. There is a smoke room with an automated fan available for smoking residents. ARC D15.3; The following equipment is available; including hoist (checked August 2013), pressure relieving mattresses and cushions, shower chairs, transfer belts, slidy sams, chair scales (calibrated August 2013) wheelchairs, electric beds, walking frames and mobility aids.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: All bedrooms are single with hand basins. There are adequate numbers of communal toilets/showers each wing. The bathroom and toilets have appropriate flooring and handrails. There are vacant/occupied slide signs and privacy locks. The staff have access to an emergency key. Call bells are available in all toilet/shower areas. There are bathroom heating fans in place.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the

room independently with the use of mobility aids. Residents and their families are encouraged to personalise the bedrooms as viewed. Six residents interviewed confirm their bedrooms are spacious and they can personalise them as desired.

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: The rest home has a large dining area, recreational room, large and smaller lounges with seating placed appropriately to allow for group and individual activities to occur. One smaller lounge is available for reading and quieter activities and church services. Residents are observed safely moving between the communal areas with the use of their mobility aids.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
All personal clothing and the facility laundry is laundered at the nearby PSC Cashmere facility. The soiled laundry is picked up from the exit door of the laundry and transported by designated van to an contracted laundry. Laundry is returned through the clean laundry entrance ready for distribution. The HCA's on nightshift iron the residents clothing as required. Adequate linen supplies are sighted. There is a small domestic laundry for kitchen washing only. The cleaner's cupboard containing chemicals and the cleaner's trolley is locked. All chemicals have manufacturer labels. Staff decant chemicals into smaller approved chemical bottles. There are dilution rations on the bottles. Staff have received training on chemical safety and re-filling of chemical bottles. An internal audit August 2013 resulted in 83%. There has been a re-audit with improvement noted. The environment on the day of audit is clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms. There are cleaning schedules in place and regular carpet cleaning is carried out by contractors.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. Fire drill was last completed on 15 October 2013. In June 2013 the service was required to undertake a full evacuation as the building was threatened by a landslide. As residents were evacuated to another PSC service, commencing at 0500 hours and residents were cleared to return to Kilmarnock Heights from 1230 hours. The three family members interviewed all report that they were very well informed and family, residents and staff report that the evacuation was well coordinated and managed. The fire service approved an evacuation plan on 22 March 2006. Following the landslide evacuation a full review was completed with learning's made and documented. D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Kilmarnock Heights is well prepared for civil emergencies and has civil defence kits. A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency flip charts were observed throughout the facility. A store of emergency water ten X 20 litre containers plus a water tank is located on the site. There are gas bottles/burners for alternative heating and cooking and emergency food supplies sufficient for three days in the civil defence cupboard. At least three days stock of other products such as incontinence products and PPE are kept. There is a store of supplies necessary to manage a pandemic. Generators have been purchased for use in an emergency and training provided in the use of the generators. An appropriate call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas, e.g. bedrooms, ablution areas, ensuite toilet/showers, lounges and dining rooms. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The facilities are secured at night and security lights are on timers. Six residents interviewed stated their bells were answered in a timely manner.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: All bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with radiator heating and maintained at a comfortable temperature. The lounge has a gas log fire. Residents and relatives interviewed confirm the environment and the bedrooms are warm and comfortable.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: There is a restraint minimisation and safe practice policy that is applicable to the service. This includes a restraint protocol for the steps from assessment, approval and into the support plan. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. The service currently has a restraint-free environment. There are currently no residents using enablers at Kilmarnock Heights. There is a restraint approval group at an organisation level that reviews restraint across all services. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures and a list of criteria for restraint that states one or more of the following conditions must be present in order for the restraint is to be implemented should this be required.

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a QPS benchmarking system in place. The scope of the infection control programme policy and infection control programme description is available. There is an established and implemented infection control programme that is linked into the risk management system. The infection control coordinator is the care manager and she works closely with the staff. The infection control committee includes a cross section of staff all areas of the service as part of the quality committee. The committee and the governing body are responsible for the development of the infection control programme and its review. Staff are well informed about infection control practises and reporting. They can contact the RN or infection control co-ordinator if required and concerns can be written in progress notes and the communication book. For after hour's requirements, the R.N. on call is available along with the infection control coordinator. Suspected infections are confirmed by laboratory tests and results are collated monthly.

Each quarter statistics are sent to the Australian QPS benchmarking programme. Summaries/graphs of these results are feedback to Kilmarnock Heights and compared with other PSC homes and homes of equivalent size in Australia.
There are guidelines and staff health policies for staff to follow ensuring prevention of the spread of infection.
There is a risk factors for nosocomial infection policy, an accidental infectious exposure, TB, management of staff found positive for MRSA, guidelines for staff visiting overseas, risks and exposures for the pregnant healthcare worker, work restrictions for healthcare personnel exposed to or infected with infectious diseases, handling deceased residents with communicable diseases, guidelines for isolation, transferring of residents with an infection , isolation policy, and procedure for when an outbreak of infection occurs. There is evidence (signage) of recent preventative measures have been taken to prevent client exposure to infectious diseases such as Norovirus and influenza.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk:	FA
Evidence:	

The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The infection control committee is made up of a cross section of staff from all areas of the service including; care giving, kitchen, cleaning and laundry and professional nurses. The facility also has access to the DHB infection control nurse, Pubic Health, Med Lab, G.P's and expertise within the organisation.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Other policies included (but not limited to) a) definition of infection for surveillance, b) IC programme description, c) standards for IC practice – cleaning, food service, linen service, waste management, d) policy and guidelines for antimicrobial usage, e) standard precautions, f) risk management of blood, g) hand hygiene, h) hand care procedures, i) UTI's, j) clinical indicators of infection, k) Hep A & B & C, l) Inoculation/ contamination emergency response, m) risk assessment plan, n) accidental needle stick blood exposure, o) TB, p) MRSA, q) documentation of suspected and actual infections, r) isolation, s) disinfection, t) outbreak procedure, u) cleaning, disinfection and sterilisation guidelines, v) single use equipment, w) waste disposal policy, and x) notification of diseases. There is also a scope of the infection control programme, standards for infection control and infection control preparation, responsibilities and job descriptions, waste disposal, notification of diseases and educational hand-outs.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)
There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)
The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence:
There is an infection control coordinator. She attended a PSC infection control nurse peer support day in April 2013, which included a variety of speakers including Bug Control. The infection control coordinator also has access to the microbiologist, pharmacist, and Med Lab for additional education for both the co-ordinator and the staff. Staff were last provided with infection control education in October 2013 and this was provided by the staff educator at a sister facility. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza. All residents have been provided with education by the clinical manager at the September residents meeting around hand washing with soap and water and hand washing using alcohol gel as part of the initiative to reduce UTI's (see CI 3.5.7)

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)
Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: CI
Evidence: The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service. The service utilises the QPS benchmarking programme, which analyses service data on a quarterly basis. The quality coordinator also conducts benchmarking against their own infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility.

Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS quarterly results as available.
All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.
Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The service has earned a continuous improvement rating for their use of UTI surveillance data to implement a project that has successfully reduced UTI rates at the facility.

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

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

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

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

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

Attainment and Risk: CI
Evidence: The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and Med lab that advise and provide feedback /information to the service. The service utilises the QPS benchmarking programme, which analyses service data on a quarterly basis. The quality coordinator also conducts benchmarking against their own infection rates from previous years by identifying K.P.I's. Systems in place are appropriate to the size and complexity of the facility. Infection control data is collated monthly and reported to the monthly quality meeting. The meetings include the monthly infection control report and QPS

quarterly results as available.
All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.

Finding:

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. In early 2013 the service recognised that UTI numbers had increased and were above the benchmark compared to other facilities. An investigation showed some residents were not drinking sufficient fluids. Water was routinely provided to each resident on the table at lunch time. However health care assistants observed that even with encouragement residents frequently did not drink this. Residents indicated they would be more likely to drink juice so juice is now provided to all residents on the lunch table and staff report most residents drink this without prompting and those who don't are happy to drink it when prompted. To further increase fluid intake the service introduced providing ice blocks to residents on hot days. Following these initiatives the September QPS benchmarking data showed a reduction of UTI's by 60% at the facility. The care manager (the infection control coordinator) reports she has continued to monitor UTI rates closely and in August 2013 noted a slight rise. She then provided education to all residents about hand hygiene including washing hands with soap and water and using alcohol gel that is located around the facility, at the September 2013 residents meeting. Following this UTI rates have dropped again in October and November 2013.

Corrective Action:

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