

Auckland Presbyterian Hospital Trustees Incorporated

Current Status: 3 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

St Andrews Village is owned and governed by Auckland Presbyterian Hospital Trustees Incorporated. The service has contracts with the Auckland District Health Board for hospital, rest home and secure dementia care and respite beds. It has three dedicated palliative care beds (the Dove Wing) which are contracted to the Eastern Bays Hospice.

The occupancy on the day of audit is 175. This is made up of 98 hospital residents, 48 rest home residents and 29 dementia residents.

The organisation has an experienced management team and the Chief Executive Officer reports monthly to the Board of Trustees on all aspects of service delivery, inclusive of all quality projects and major improvements. There is a developed, implemented and sound quality and risk management system that is regularly reviewed and refined to further improve service delivery and minimise risk. All service areas (houses) have been designed to provide a homely environment giving due consideration to the comfort and safety of the residents.

There are four areas of 'continuous improvement' ratings attained in relation to organisational management, service delivery and one for safe and appropriate environment. These areas are particular strengths of the organisation.

Audit Summary as at 3 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 3 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.
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Organisational Management as at 3 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.		All standards applicable to this service fully attained with some standards exceeded.
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Continuum of Service Delivery as at 3 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.		All standards applicable to this service fully attained with some standards exceeded.
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Safe and Appropriate Environment as at 3 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.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint Minimisation and Safe Practice as at 3 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.
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Infection Prevention and Control as at 3 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.
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Audit Results as at 3 December 2013

Consumer Rights

Services are provided in a manner that respects the Code of Health and Disability Services Consumers' Rights (the Code) and facilitates informed choice. The Code is clearly displayed. Residents and relatives interviewed expressed their satisfaction with services and believe staff are providing appropriate care and they are treated with respect and dignity. Interpreter and advocacy services are available. Residents, and where appropriate the family/whanau, are provided with information to assist them to make informed choices and give informed consent.

This large organisation has appropriate policies, procedures and a staff education programme to ensure the recognition of Maori values and beliefs. The service provides care that recognises and respects the resident's individual culture, values and beliefs.

There is a policy documented and implemented on open disclosure and effective communication is evident and demonstrated between the nurse managers and the general practitioner interviewed.

There is a documented complaints process which is implemented to ensure all complaints are followed up and information is used as an opportunity to improve service delivery as appropriate. At the time of audit there are three recently received complaints that are open, none of which are of a serious nature.

Organisational Management

St Andrews Village undertakes strategic business and quality and risk planning that matches their mission statement and goals and allows them to provide services to meet the needs of residents.

There are very robust quality and risk management systems in place which are reflective in all documents sighted. There are two particular strengths within the quality and risk system relating to quality improvement data collection, analysis, evaluation and feedback to staff and where appropriate residents. These are rated as `continuous improvement`.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whanau interviews, and in the satisfaction survey results

sighted.

The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes are implemented to reflect current good practice and meet legislative requirements. The knowledge and skills of staff are maintained through on-going education which is appropriate to their role.

Resident and staff records are maintained to a high standard and confidentiality is respected. Documentation and resident information collected meets legislative requirements. A resident register is accurately recorded. Records are stored securely and are accessible when required.

Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of the residents in the rest home, hospital and the dementia unit. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. Two clinical managers oversee the care and management of all residents along with nurse managers in all service areas. All residents have been assessed appropriately prior to admission and assessment details are retained in the individual resident's records reviewed.

Assessments are appropriate and based on good practice. The residents' care plans are well documented and clearly identify the needs, outcomes and or goals and these are reviewed on a regular basis, six monthly or more often as required, with resident and family input being sought. Short term care plans are used as required to guide service delivery for residents who have short term needs. A general practitioner interviewed verified that all residents are seen within 48 hours of admission and explained that full medical cover is provided for all residents 24 hours a day.

The activities available are appropriate for dementia, rest home and hospital level care residents. These include community groups coming to the facility and external visits. Over the past 18 months changes have been made to provide an all inclusive programme (that is, family, residents, staff and friends) and survey results show an increase in resident attendance and positive feedback regarding the changes.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo competency assessment annually. The charge nurse in each area is responsible for all areas of medication management and works alongside a contracted pharmacy, who oversees controlled drugs and prescribed medication.

The food service is contracted and an experienced food service manager is contracted to manage this service. The menu plans for winter and summer have been reviewed by a contracted dietitian to ensure they are suitable for the elderly and/or disabled. The six weekly menus have been fully approved. The resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen evidences compliance with current legislation and guidelines.

Safe and Appropriate Environment

The emergency response processes which are clearly documented and regularly reviewed are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. The analysis and monitoring process of disposal of all waste products is a strength of this service

Six monthly fire evacuations and on-going emergency education is undertaken to ensure all staff understand how to deal with emergency situations. The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

The facilities are fit for purpose and provide furnishings and equipment that are maintained to a high standard and are appropriate and accessible for rest home, hospital and residents with dementia. The service has 10 existing beds that have been approved for either rest home or hospital use, which meet the needs of residents. All bedrooms are single occupancy, and with the exception of the older free standing rest home 'Lodge' building, they have ensuite facilities. The dining and lounge areas meet residents' relaxation, activity and dining needs.

The facility is heated via gas and is ventilated through opening doors and windows. There are appropriate outdoor areas that have seating and are sheltered for residents' use. Residents have access to well-maintained outdoor areas with appropriate seating and shelter, including the dementia care unit which has secure internal garden areas.

Restraint Minimisation and Safe Practice

The organisation has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. All staff have received training in de-escalation techniques for managing challenging behaviour and education about the service policy, regulations and safe and effective alternatives to restraint.

Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes.

A full information brochure is given to all family members when restraints or enablers are being considered for a resident. For residents receiving a form of restraint full assessments, approval and monitoring of the restraint occurs. Appropriate documentation was reviewed and the experienced restraint co-ordinator maintains an accurate restraint register. Restraint is only used as a last resort. Safety is promoted at all times.

Infection Prevention and Control

St Andrews Village has an infection prevention and control programme which is dated as being reviewed in 2013. There is an Infection Prevention Control (IPC) team who meet monthly and report to the staff on any issues relating to IPC. There has been one notifiable outbreak at the facility and this was managed and contained. Surveillance is occurring for residents who develop infections and these are reported to the IPC team monthly.

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:	Auckland Presbyterian Hospital Trustees Incorporation		
Certificate name:	St Andrew's Village		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Certification		
Premises audited:	207 Riddell Rd, Glendowie, Auckland 1071		
Services audited:	Hospital Care Medical - Hospital Care Geriatric - Rest Home - Dementia Care.		
Dates of audit:	Start date: 3 December 2013	End date: 4 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:			

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	32	Total hours off site	16
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	3

Sample Totals

Total audit hours on site	48	Total audit hours off site	27	Total audit hours	75
Number of residents interviewed	14	Number of staff interviewed	24	Number of managers interviewed	6
Number of residents' records reviewed	19	Number of staff records reviewed	14	Total number of managers (headcount)	9
Number of medication records reviewed	38	Total number of staff (headcount)	147	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 13 January 2014

Executive Summary of Audit

General Overview

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There are four areas of 'continuous improvement' ratings attained in relation to organisational management, service delivery and one for safe and appropriate environment. These areas are particular strengths of the organisation.

Outcome 1.1: Consumer Rights

Services are provided in a manner that respects the Code of Health and Disability Services Consumers' Rights (the Code) and facilitates informed choice. The Code is clearly displayed. Residents and relatives interviewed expressed their satisfaction with services and believe staff are providing appropriate care and they are treated with respect and dignity. Interpreter and advocacy services are available. Residents, and where appropriate the family/whanau, are provided with information to assist them to make informed choices and give informed consent.

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There is a documented complaints process which is implemented to ensure all complaints are followed up and information is used as an opportunity to improve service delivery as appropriate. At the time of audit there are three recently received complaints that are open, none of which are of a serious nature.

Outcome 1.2: Organisational Management

St Andrews Village undertakes strategic business and quality and risk planning that matches their mission statement and goals and allows them to provide

services to meet the needs of residents.

There are very robust quality and risk management systems in place which are reflective in all documents sighted. There are two particular strengths within the quality and risk system relating to quality improvement data collection, analysis, evaluation and feedback to staff and where appropriate residents. These are rated as `continuous improvement`.

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The service implements safe staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes are implemented to reflect current good practice and meet legislative requirements. The knowledge and skills of staff are maintained through on-going education which is appropriate to their role.

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Outcome 1.3: Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of the residents in the rest home, hospital and the dementia unit. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. Two clinical managers oversee the care and management of all residents along with nurse managers in all service areas. All residents have been assessed appropriately prior to admission and assessment details are retained in the individual resident`s records reviewed.

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current legislation and guidelines.

Outcome 1.4: Safe and Appropriate Environment

The emergency response processes which are clearly documented and regularly reviewed are understood and implemented by the service as required. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. The analysis and monitoring process of disposal of all waste products is a strength of this service

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Outcome 2: Restraint Minimisation and Safe Practice

The organisation has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. All staff have received training in de-escalation techniques for managing challenging behaviour and education about the service policy, regulations and safe and effective alternatives to restraint.

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Outcome 3: Infection Prevention and Control

St Andrews Village has an infection prevention and control programme which is dated as being reviewed in 2013. There is an Infection Prevention Control (IPC) team who meet monthly and report to the staff on any issues relating to IPC. There has been one notifiable outbreak at the facility and this was managed and contained. Surveillance is occurring for residents who develop infections and these are reported to the IPC team monthly.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	3	47	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	CI	
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of all quality data which is gathered from key components of service and is benchmarked against previously collected data. Corrective actions are clearly documented and monitored for effective outcomes. Many corrective actions are written up as ongoing projects, such as the waste management project.

Code	Name	Description	Attainment	Finding
				Educational material includes written and pictorial evidence which was presented to staff so they gained a full understanding of the required outcome. This has resulted in a 100% compliance with rubbish separation and disposal. This has resulted in an improvement to environmental safety.
HDS(C)S.2008	Criterion 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.	CI	Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis and monitoring process of all identified risks and hazards. Corrective actions to manage the hazard and/or risk are clearly documented and the outcome is monitored by the health and safety team who also inform the person who reported the risk of actions taken and the outcome. Risks are reviewed, evaluated and monitored at each health and safety meetings and at least six monthly by the CEO who shares his findings at BOT level. The risk management process that is implemented ensures that services are offered in a manner that respects the safety of everyone who visits, lives or works at St Andrews and allows ongoing service delivery improvement.
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	Having fully attained the criterion the service can clearly demonstrate a review, analysis and monitoring process related to activity attendance. A quality improvement project has been undertaken which has included the development of an activities statistic form which demonstrates the changes implemented in the activity programme over the past 18mths has increased attendance. The data from the activities statistics form has been monitored by the diversional therapist and the success of the outcome is measured by the number of residents that attend activities

Code	Name	Description	Attainment	Finding
				offered .Resident satisfaction with activities offered is confirmed in the resident satisfaction survey and during interview.
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	CI	
HDS(C)S.2008	Criterion 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.	CI	<p>Having fully attained the criterion the service can in addition clearly demonstrate that review and analysis of each step of a project undertaken related to safer, more efficient separation and disposal of waste products. The findings from a September 2013 audit are written up as corrective actions and owing to systemic nature of the problem developed into a major project. The corrective actions taken resulted in clearer written instructions related to waste management being included in the infection control programme.</p> <p>Documentation and data sighted related to the project identifies that the waste management processes have been re-audited in October and November 2013 and results show that compliance and staff understanding of policy has increased from 33% to 100% resulting safer, environmentally friendly practices being undertaken.</p>

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:

Consumer Rights policy and procedure sighted acknowledges how the service will ensure consumer rights are fulfilled and states a copy of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is provided in the information pack and this will be discussed at admission and on display. The Code is displayed in both Maori and English versions and the pamphlets and booklets are readily accessible. The quality co-ordinator interviewed stated that the service has been audited to ensure compliance with the Code of Rights annually. All new employees undergo a service orientation and the Code is covered. The service has an advocacy service which is readily available with a Chaplain and counsellor on site and the Health and Disability Advocacy Service pamphlets with relevant contact numbers are displayed at reception and in all service areas around the facility. Staff interviewed (24 including 15 clinical and 9 non-clinical staff) have a good understanding of the Code. Clinical staff ensure that this understanding of consumer rights is incorporated as part of their everyday practice and care of the residents.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

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

Consumers are informed of their rights.

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

Attainment and Risk: FA
Evidence: A consumer rights policy and procedure states the Code will be discussed on admission to this service. Opportunities will be provided for explanations, discussions and clarification about the Code and information about the Nationwide Health and Disability Advocacy Service will be made available. This is evident with posters clearly displayed in both English and Maori. Pamphlets are readily available on the Code and advocacy services. The Health and Disability Commissioner's office website has the Code information available in multiple languages. Interpreter services are available through the Auckland District Health Board. The Nationwide Health and Disability Advocacy Service is available and the contact numbers are documented on the reverse of the advocacy pamphlet or alternatively the numbers are documented on the reverse of the Code information pamphlet since this was reviewed in 2012. The three nurse managers interviewed are trained to talk to residents' family/whanau/representative as needed. ARRC requirements are met.

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

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

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

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

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: <p>A privacy and dignity policy and procedure is available which clearly defines and states the privacy and dignity needs of the residents will be maintained at all times in line with the requirements of the Privacy Act 1993 and the Health and Disability Services Standards. Associated policies such as the privacy and confidentiality policy provides clear definitions of privacy and confidentiality and clear examples of how this can be maintained by staff and outlines staff responsibilities in relation to personal privacy, dignity and respect whilst providing cares and maintaining independence of residents. There is a comprehensive policy and procedure maintaining culture, value and care and a policy for abuse and neglect which has clear definitions of what constitutes abuse and how staff can recognise and identify the signs and symptoms and how and who to report suspected abuse. Policy states there is availability of pastoral (including spiritual) care.</p> <p>There is one chaplain and one counsellor employed for this service who are available at all times for staff, residents, family/whanau as required. A chapel sighted is available on site and provides a restful quiet environment for residents/family/whanau. Posters are displayed in all service areas of this service available. All staff interviewed (24 in total 15 clinical and nine 9 non-clinical) are very well informed and acknowledged the importance of being respectful towards all residents and maintaining confidentiality and privacy at all times.</p> <p>On the tour of the facility it was observed that there are doors to close, signage, curtains to be pulled and locks are available on the bathroom doors. Security is maintained at all times. Security systems are in place for ensuring the residents' belongings are protected and entrance doors are locked after hours. Contractors sign in when visiting this residential aged care service.</p>

The three nurse managers interviewed ensure the cultural values and beliefs are taken into consideration when planning individual care for each resident. Consents, choices and options are discussed with the residents/family/whanau/representative when providing appropriate cares while at the same time maintaining resident's independence. Seven of seven healthcare assistants interviewed have received education (March 2013) and have a good understanding of abuse and neglect and how to report any suspected incidences to the nurse managers in their respective service areas. The nurse managers explained the InterRAI protocol and additional recognised assessment tools utilised to identify the needs of residents during the assessment process. The 19 of 19 care plans sighted (three dementia unit, six rest home, ten hospital) reflect the identified needs and wishes of residents, inclusive of social and spiritual needs.

ARRC requirements are met.

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

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

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

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:

There is a comprehensive Maori Residents: Cultural, values and care policy, which describes the expectations when providing care and services for residents who identify as Maori. The policy states that St Andrew`s Village (SAV) is committed to delivering culturally appropriate care and service. Residents who identify as being Tangata Whenua are part of the SAV obligation to Te Tiriti o Waitangi principles of partnership, participation and protection. The service provides two yearly mandatory training on Te Tiriti o Waitangi and six monthly training opportunities for all staff with respect to cultural safety. There is also a policy culture, values and care which outlines the expectations of services and how to meet these when providing care and services for residents that identify as Maori.

There is Tikanga best practice guideline available to guide staff on how to deliver safe and effective services for Maori. The importance of whanau is acknowledged by staff interviewed and family/whanau are encouraged to visit and to provide support. Values and beliefs identified during the assessment process are taken into consideration and documented on the individual resident`s care plan. There are three staff employed who identify as Maori and one resident. The quality co-ordinator interviewed has sought consultation with and is working closely with the Auckland District Health Board (ADHB) Maori health advisors to review and to improve the current policies and procedures and input of Maori advisory services.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The culture, values and care policy was sighted which outlines the expectations of services which meet individual resident's cultural personal requirements, preferences and beliefs. Additional references and information is accessible and can be obtained from the ADHB and Asian health website. Staff interviewed (both management and clinical and non-clinical staff) displayed awareness of the needs of many cultural groups in relation to food service requirements and support person presence and/or understanding cultural rituals in the case of death in the different services. The photographs of all staff in each area visited evidenced staff employed represent many different cultures as well as the residents. Resident ethnicity is recorded. Any specific needs of residents identified during the assessment process on admission are documented on the individual resident's clinical records.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not subjected to any form of coercion, harassment, sexual or other exploitation. Professional boundaries of staff are to be maintained for the well-being of the residents. All registered nurses are required to complete compulsory Code of Conduct training for the New Zealand Nursing Council (NZNC) by 2015, so many staff have already completed this as part of their mandatory education for registration in 2014. Staff interviewed (three nurse managers and two registered nurses) are well informed and fully aware of the processes to follow if an incident arises and who the incident should be reported to.

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: Evidenced-based practice is observed, promoted and encouraged for good practice, as evidenced in interviews with the clinical manager, nurse managers, staff in all services and displays sighted in each service area. This is also reflected in the comprehensive education programme available for all staff and the excellent attendance records maintained and sighted. Competencies for senior health care assistants and registered nurses are also maintained and all relevant information is current and up to date. Policies and procedures and information sheets are examples sighted of evidence based practice and go through a quality process when developed, reviewed and prior to approval and implementation. All sources of information are referenced on the policies sighted. Examples of evidence based good practice is the infection control initiated poster competition for hand hygiene which resulted in one poster being selected, printed and laminated and displayed at every hand basin in the facility. There is a staff member of the month promotion and recognition programme, with a photograph of the staff member and information displayed for staff/residents/family/whanau to view in each service area. The clinical quality improvements/outcomes are displayed on the staff notice boards also for staff/residents/family to view in each service. Evidenced-based practice is observed as documented, promoted and encouraged across all services by the CEO and quality management team. ARRC requirements are met.

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

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

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

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:

Policy on open disclosure defines and clearly describes what open disclosure is to guide staff. The policy states that open disclosure contributes to the foundation of a successful service provider relationship by ensuring trust, is a right of a resident under the Code and is part of the move towards increased accountability from staff. Open disclosure is required for the informed consent process, especially when there is a need of further treatment or care and is a demonstration of the philosophy of valuing residents and families as part of the team with a family centre approach to care delivery. There is an interpreter/translation policy available to guide staff on who to contact as required. The clinical manager, one general practitioner and three nurse managers interviewed have a good understanding of open disclosure and the resident's right to full and frank information and open disclosure from staff. Informed consent policies are also available to guide staff and for open disclosure. A resident centred approach to service delivery and open communication is respected by staff. A communication book is available in all services. Family meetings are held and this was verified with the two residents interviewed from the hospital and the rest home and family member of one patient in the dementia unit. For any complaints or investigations the resident/family/whanau would be informed of any investigations or involvement required. Handover records are used between all shifts in all service areas by staff and this system and form of good communication works effectively.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a clearly defined informed consent policy on the definition of informed consent and the obligation to provide appropriate information for residents/family/whanau to make informed choices and give informed consent when and if required. Policies are available for advance care approaches and cardiopulmonary resuscitation (CPR) outlining the expected standards. A CPR treatment plan is available in the form of a flow chart outlining staff responsibilities and management of resuscitation. Informed consent forms have been reviewed, approved and re-implemented. The general practitioner discussed the improvement of the new documentation which is managed effectively and understood by senior staff involved with this process. All 19 of 19 residents' records reviewed evidenced informed consent forms being signed appropriately and supporting information being provided to residents/family/whanau as required. All informed consent forms are retained in the individual resident's records.</p> <p>Advanced care planning has been implemented, and in the hospital, it was noted that a sticker is placed on the files if this is in place. One of ten hospital level records sighted had an advance directive documented when in a previous facility and this has been reviewed with the general practitioner and one hospital level resident . Informed consent was obtained verbally.</p> <p>ARRC requirements are met.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: A consumer rights policy states information will be provided on admission regarding advocacy and support services available. The Nationwide Health and Disability Advocacy Service brochure along with contact details is readily available for residents/family/whanau/representatives in the information pack provided and in the pamphlet stand at reception and in all service areas. The `Your Rights Posters` are displayed in both English and Maori. The senior staff interviewed (the clinical manager, the nurse managers and the quality co-ordinator) follow the investigation process for this organisation and the complaints process when required which recommends an advocate and/or support person for any staff member involved. The organisation also has links with New Zealand Aged Concern and contact details are readily available. ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has clear links with family/whanau and visitors are very welcome to this facility and to special events organised with residents, their families and friends. Visiting times are very flexible but arrangements can be made with the nurse managers concerned. The two clinical managers are available to families as well as the individual nurse managers for each care setting. Quarterly newsletters are developed and implemented and all families receive a copy. Additional copies are available in all houses for residents. Family members and residents are invited to the six monthly multidisciplinary review meetings held for each resident. Family have input into the care planning and the activities programme to meet the needs of the individual resident concerned. Links are maintained with activities in the community being encouraged as part of the activities programme. Van outings into the community or attendance at church services at local churches is encouraged. Pastoral care services are available and visitors come to the rest home and hospital on a regular basis. School children and kinder-garden children from the region often visit the rest home and hospital and provide entertainment which is well received by the residents. Residents can be taken to the local returned service association (RSA) club or other services for outings in the community and this is sighted on the activities/recreational programme.

ARRC requirements are met.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Documentation review: There is a comprehensive complaints and concerns policy. The policy describes the expectations of all aspects of identification and manages complaints and concerns and to make clear the philosophy underpinning St Andrew's Village that all complaints or concerns are reviewed for contributing to continuous system improvement. Clear definitions of complaints are documented and the complaints procedure is clearly outlined from receipt of a complaint/concern to resolution.</p> <p>Stage two: St Andrews Village implement the complaints procedure as identified in policy. Complaints forms are located in every house (wing) and at the main reception area. All complaints are documented and a letter of acknowledgement and information about the Health and Disability Commissioners' complaints process is sent to the complainant. The complaint is assigned to an appropriate manager for follow up and it is monitored by the quality, risk and audit manager (QRA) to ensure timelines are met and that close off is gained.</p> <p>Complaints management is also discussed and explained as part of the admission process. This is confirmed during interview with three of three family/whanau and 14 of 14 residents (seven rest home and 7 hospital) who all understand the complaints process and would feel comfortable making a complaint.</p> <p>Interviews with 24 of 24 staff (nine health care assistants (HCAs), four RN nurse managers, two RNs, the maintenance officer, one diversional therapist, three activities coordinators, one physiotherapy assistant, one laundry assistant, the trainer/educator, one IT support person and six members of the senior management team) confirm their understanding of the complaints process.</p> <p>The complaints register sighted includes the date the complaint was received, the date of the written response, identifies the area and issue of the complaint, a risk rating</p>

and who the complaint is sent to for response. The investigation outcome and any corrective actions or quality improvement put in place is identified. This information is then transferred to the quality improvement data spreadsheet to ensure appropriate follow-up and to measure the outcome. One example relates to concerns identified by one family/whanau related to their relative's behaviour and limited communication with the medical staff, the bedroom cleaning status and difficulty finding required information. Follow-up includes documented discussions with the GP, staff education on the changing needs of residents, more frequent reporting process to the contracted cleaning supervisor with an increase in cleaning audit timeframes, with results being shared with the St Andrews Village support manager and an update of the public website to make it more user friendly.

All complaints data is shared at staff and management meetings as confirmed in minutes sighted. Complaints of a serious nature are escalated to senior management and the CEO reports to the Board of trustees as appropriate. At the time of audit there are three outstanding complaints, not of a serious nature, awaiting completion and sign off.

ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: The organisation has a quality management framework which describes the structures and processes to ensure that St Andrews Village meets the vision of achieving excellence in aged care and, co-ordinates potentially disparate aspects of quality improvement, safety and management and emphasises quality improvement approaches and methodologies and 'compliance' culture, along with risk management systems.

The quality framework is outlined in a flow chart with the organisational mission vision, values and strategy. It is clearly documented as structure, governance and leadership, getting it right: including risk management, doing the right thing: being resident and family focused and being up to the job: competence and education.

The flow chart is self-explanatory and is based on the dimensions of quality management and abiding with the Treaty of Waitangi at the same time. An example is: Structure governance and leadership as the objectives and how this can be achieved is clearly documented as, for example, effective business strategies, committee structure including quality and risk management, communication and best practice, resident and staff safety, emergency planning, leadership and management best practice and records and document management including privacy. Getting it right by knowing the standards. Evidenced base, certification, effective policies and procedures, monitoring of performance against standards, risk management framework, infection control and resident care pathways (eg, LCP, quality improvement tools in use and equipment management). Doing the right thing by highest possible degree of autonomy for people in care, resident and family feedback, best practice response to complaints, diversity of approach, resident and family involvement in planning and review, readable written information for residents and families, caring attitudes, service and environment, quality of life measures as defined by residents. Lastly being up to the job is evidenced by orientation to the service, effective training, staff support and development, supervision as required, peer reviews and journals, performance review PDRP, engagement with sector leaders and other providers, course and conferences attended.

Part two: St Andrews Board of Trustees (BOT) ensures governance of all services. There are subcommittees for strategic planning, finance and risk, clinical governance and property. The monthly meetings ensure that the strategic direction is being maintained, they monitor the progress of business and quality key performance indicators via information from departmental reports received, they also respond to urgent quality and risk issues and ensure quality improvements are meeting timelines. The September 2013 strategic planning meeting of the BOT and the executive management team agreed on strategies to look at ongoing service configuration to meet future resident and community needs.

All services are overseen by a Chief Executive Officer (CEO) who has been in the position since December 2011. The CEO has worked at the facility for over eight years in management roles and is a Fellow of the Chartered Association of Certified Accountants (FCCA) obtained in 2001. He undertakes ongoing education that is appropriate to his role and regularly attends Employer and Manufactures Association (EMA), Auckland DHB and Age Care Association education, seminars and conferences. He is supported by a team of managers (the executive team) who are appropriately qualified.

The executive team is made up of the Human Resource (HR) Manager, the Quality, Risk and Audit (QRA) Manager, the Service Support Manager, the Accounts Manager, Admission's Manager, Village Manager and two Clinical Managers (CMs) who are responsible for the day to day management of clinical oversight. Both CMs hold current annual practising certificates, have worked previously in management positions in aged care and have completed education related to dementia care. The HR manager is involved in the review and development of educational standards at a National strategic level for HCAs and with Careerforce in creating a recognised qualification for managers working in aged care. The CMs are part of the Auckland DHB steering group reviewing falls and pressure injuries and how they can be decreased.

Each staff member's authority, accountability and responsibility for the provision of services is clearly set out in job descriptions sighted.

Interviews with 14 of 14 residents (seven rest home and seven hospital) and three of three family/whanau members confirm they are very happy with the services offered and that their needs are met.

ARRC requirements are met

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The HR manager undertakes the CEO role when required to cover annual leave or sick leave. St Andrews Village undertakes succession planning to ensure cover for members of the executive team. The BOT are very supportive and available for assistance and advice at any time. ARRC requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: CI

Evidence:

Documentation Review: Policy states that the organisation operates an environment in which continuous quality improvement is a core philosophy of business. The quality plan 2013 – 2014 works hand in hand with the organisations strategic and business plans. Quality measures will be planned and undertaken and outputs from these measurements will be used to ensure continuous quality improvements for all services. Responsibilities of staff are designated on the action plan sighted. The organisation develops and implements policies and procedures that are aligned with current good practice and service delivery that meets the requirements of legislation and are reviewed as per the review schedule. The policies and procedures sighted have all been dated and approved by the CEO or one of the two Clinical managers (CMs). Monitoring is ongoing but at least two yearly for all policies and procedures.

Stage two: St Andrews Village is able to demonstrate that all quality and risk management systems are implemented throughout the organisation. The BOT monitor the quality plan timeframes which identify how safe, timely effective, efficient, equitable and resident and family/whanau centred actions are achieved. The quality framework is clearly linked to the organisational mission vision, values and strategic planning and key elements of quality are described in all policies, procedures and planning documents sighted. All aspects of the quality plan (2013-2014) are linked to the strategic and business plans and it is clearly documented who is responsible for each nominated action and when issues will be completed. For example, all corrective actions are entered onto a register which is monitored by the CQI group monthly and by the executive management team three monthly.

Monthly CQI meeting minutes identify that quality data is collated, analysed and trended against previously collected data and used to ensure opportunities for service improvements are documented, implemented and followed up. The organisation has robust quality systems in place. Quality data is collected from the following sources:

- incidents and accidents (including serious incident)
- the audit and monitoring programme
- complaints and compliments
- infection control
- hazard reports
- restraint
- call bell reports
- activities and physiotherapy

Staff interviews confirm their understanding of the CQI processes in place. Staff are kept fully informed both verbally and in writing of all quality issues and surveillance data results from the key performance components of service. Clinical quality indicator reports available to all staff include falls, pressure areas, restraint, infections,

medication errors, health and safety and incident/accidents and trended results. Discussions around these results and topics are standing agenda items in both staff and management meetings. Staff are kept well informed via data results being posted on the staff room notice board, regular monthly staff meetings, during per shift handover, documentation in the handover book and they are trialling the use of hand held electronic tablets.

At a clinical level the QRA manager facilitates corrective action planning and ensures timeframes are met and that all outcomes are measured. This is undertaken on an electronic data base.

All policies and procedures sighted are up to date and have been reviewed within the last two years or sooner. Policies and procedures are approved by the CEO or CMs following CQI group input and staff consultation as appropriate. Due dates are shown on each policy and there is an electronic system in place to remind the 'owner' of the policy that it is due for review and update. Information is available to staff in both hard copy and electronically.

Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed by the CQI committee and any newly identified hazards that cannot be eliminated are added to the register. The risk register is also monitored by the CEO at least six monthly. Staff confirm during interview that they understand and implement documented hazard identification processes.

Having fully attained the criteria 1.2.3.6 and 1.2.3.9 the service can in addition clearly demonstrate a review and analysis process of all quality data and risk management processes which incorporates all key components of service and is benchmarked and monitored to improve service delivery and ensure staff, resident and visitor safety. These two criteria have gained a continued improvement rating.

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: CI
<p>Evidence:</p> <p>Quality improvement data is analysed and evaluated and the results are communicated to staff, management and the board on at least a monthly basis. Residents are kept informed as appropriate. Results of all quality data is also printed off in hardcopy and placed in a folder in each nurses' station. Quality data covers all aspects of service delivery including adverse events, complaints, infection control, health and safety and restraint. Staff confirm during interview their understanding, involvement and commitment to quality improvements.</p> <p>Members of the senior management team include all quality data and any targeted areas for improvements in quarterly reports to the relevant board committees.</p>
<p>Finding:</p> <p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of all quality data which is gathered from key components of service and is benchmarked against previously collected data. Corrective actions are clearly documented and monitored for effective outcomes. Many corrective actions are written up as ongoing projects, such as the waste management project. Educational material includes written and pictorial evidence which was presented to staff so they gained a full understanding of the required outcome. This has resulted in a 100% compliance with rubbish separation and disposal. This has resulted in an improvement to environmental safety.</p>
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

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

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

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

Attainment and Risk: CI

Evidence:

The service has an electronic hazard register that is a living document. Specific forms are used and information is transferred onto the hazard register risk report until the issue is eliminated. If it cannot be eliminated documentation shows how it is isolated or minimised to ensure it is safely managed. All newly identified risks are entered onto the register until they can be eliminated. If it is not possible to eliminate the risk it is minimised or isolated and actions are shown on how to manage the risk. Regular reviews are undertaken and the process is fully understood by all staff interviewed. Risks shown cover all aspects of service delivery including financial and business risk. Meeting minutes and other detailed documentation sighted shows how risk management is dealt with and that it is embedded into everyday practice. Staff and management are kept fully informed of any new risks and residents are informed as appropriate.

Finding:

Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis and monitoring process of all identified risks and hazards. Corrective actions to manage the hazard and/or risk are clearly documented and the outcome is monitored by the health and safety team who also inform the person who reported the risk of actions taken and the outcome. Risks are reviewed, evaluated and monitored at each health and safety meetings and at least six monthly by the CEO who shares his findings at BOT level. The risk management process that is implemented ensures that services are offered in a manner that respects the safety of everyone who visits, lives or works at St Andrews and allows ongoing service delivery improvement.

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:

Documentation Review: There is a policy for adverse event reporting for all adverse, unplanned or untoward events that have to be systematically recorded by the service and reported appropriately. There are processes in place to guide staff actions in relation to open disclosure and the open disclosure policy sighted is available. This outlines what should happen in the event of an adverse event when a resident has suffered unintentional harm while receiving care or an error that affected care but does

not appear to have caused harm may also need to be disclosed to a resident and their family/whanau.

Stage two: Senior members of the management team are aware of the reporting processes required in relation to serious harm, infection control outbreaks or suspicious death. They confirm they would ensure policy requirements are implemented.

Documentation sighted in ten of ten hospital, three of three dementia and six of six rest home level care resident files, meeting minutes and interviews with three of three family/whanau members confirms that adverse events are recorded, reported and information is shared as appropriate. The principles of open disclosure are maintained by the service.

St Andrews Village uses incident and accident forms to document adverse, unplanned or untoward events. Corrective actions are clearly documented and signed off by the QRA manager and/or the CEO when completed. Shortfalls identified are used as an opportunity to improve service delivery and all information is shared with staff as confirmed in meeting minutes sighted. Data collected from incident and accident reports is reported in specific groups such as falls, pressure area and staff accidents so that opportunities for improvement can be identified. All incident and accident forms are seen by the clinical manager in the area concerned and a risk rating is applied. This determines the monitoring and follow-up required and the level of senior management involvement required. Corrective action planning is undertaken as required.

The outcome of corrective action planning is monitored and an example sighted identifies that the number of serious harm events related to resident falls has decreased from 13 in 2012 to 8 in 2013. This equates to a greater than 20% reduction in falls resulting in serious harm which is an identified key performance indicator for quality processes. During interview with the QRA manager it was identified that changes have been made by the organisation to the content and frequency of the manual handling training and to the resident falls assessment tool which have assisted in the lower of the falls resulting in serious harm.

The service has a serious incident review panel which has set terms of reference including investigating and reporting on serious harm and ensuring sharing of learnings gained from the incident.

Interviews with four RN nurse managers, two RNs and nine of nine HCAs confirm their understanding of the incident and accident process and the need to document and report all adverse events.

ARRC requirements are met

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: Job descriptions are available for all staff positions. Staff records will be sighted on site. Management will employ the best possible and most appropriate person for each vacancy without any discrimination and as per the human resource policies and procedures. As per the quality plan sighted all new staff will be supported to assist them to integrate into their work environment and role. St Andrews Village will provide the necessary training and support to enable all new employees to perform the functions of their role to the set standard of the organisation.

Stage two: There is a system in place to record annual practising certificates for staff that require them. This is maintained and recorded by the Human Resource (HR) Department as identified in documentation sighted. The data base covers RNs, ENs, medical staff, pharmacists, podiatrist, diversional therapist and physiotherapist.

A review of 14 of 14 staff files (the HR manager, one CM, the QRA manager, one RN, one EN, one DT, one maintenance person, one laundry worker and six HCAs – one senior and one recently employed from each of the three areas - hospital, rest home and dementia care) and interviews with 24 of 24 staff from across all areas of the service confirm that the orientation process prepares staff for the roles they undertake. Documented orientation covers all aspects of service relevant to the role the employee undertakes. Good HR practices sighted in all the files reviewed which contained signed employment agreements, job descriptions, completed orientation, restraint minimisation competencies and medication competencies as appropriate, staff education, current work permits, annual practising certificates and up to date staff

appraisals.

All new staff receive a staff handbook with general information. The orientation manual given also contains general information and is a resource containing documents such as the Code and a guide for writing progress notes. Staff are given two months to complete the orientation package and this is monitored by the HR manager. All files reviewed had an orientation checklist showing what orientation was completed. The induction process includes senior staff acting as preceptors for new staff. This is an approved role and to become a preceptor staff must pass a dedicated competency.

The list of staff with current first aid certificates shows that 143 of the 147 staff employed hold this qualification. Medication competencies are shown for all RNs, ENs and for 46 HCAs. Every individual staff member has an up to date list of education undertaken. Education is related to the role the staff member performs and both onsite and offsite education is advertised for all staff. Staff interviews confirm they are satisfied with the amount and type of education offered and that during annual appraisals they have an opportunity to identify any specific area of education they wish to pursue. Staff confirm that all education and training is well advertised and that they are encouraged and supported by management to attend ongoing education. HCAs are required to undertake recognised qualifications such as Aged Care Education (ACE) via Careerforce if they choose to work in the dementia care unit. ACE training is offered to all HCAs and the service has five Careerforce assessors to assist staff with this.

The HR manager monitors education offered off site to ensure all staff have the opportunity to attend courses they are interested in, and that as many different staff gain knowledge and skills in the areas they are employed to work. The organisation has an approved professional development and recognition programme in place for all RNs and ENs. This is undertaken in conjunction with Auckland DHB.

The education plan and content sighted identifies that since the new training facilitator has been employed (2013) well over 90% of staff have undertaken mandatory training which includes abuse and neglect, challenging behaviour, Code of Rights, continence management, cultural safety, fire, health and safety, infection control, manual handling, privacy and confidentiality, and informed consent.

Interviews with seven of seven hospital, seven of seven rest home residents and three of three family/whanau members confirm services are delivered in a manner that is professional and meets their needs.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>St Andrews Village implements a documented process to determine service provider levels and skill mixes are provided in all areas at all times to safely meet the needs of residents. A review of rosters identifies that a combination of senior and intermediate staff cover all areas and the HR manager stated that junior staff are placed into areas to ensure there is an even mix of all staff. All shifts and areas are covered by RN and ENs as appropriate. Night shift always has two RNs who cover all areas and in the afternoon there are RNs rostered for the hospital and dementia areas and either a RN or EN in the rest home area (the Lodge) as well as a dedicated afternoon supervisor. HCA coverage is maintained on all shifts which surpass the documented staff to resident ratio required to meet contractual requirements.</p> <p>There is a member of the senior management team on call at all times and this includes a clinical staff member. GP coverage includes an on call component. Staff interviews and rosters sighted confirm there is adequate staff on at all times and that the ratio of staff is increased if the number of hospital level residents increases owing to the newly approved 'swing beds' which can be either rest home or hospital level care residents.</p> <p>Dementia Care: Staff who are rostered into the unit have either completed or are part way through a recognised dementia care specific educational qualification.</p> <p>Palliative Care: There are three dedicated palliative care beds which are contracted by Eastern Bays Hospice. The HCAs who work in this area have undertaken specific education provided by the hospice and are approved by them to work in the area. Specialised oversight is undertaken by hospice staff with day to day management being overseen by employed RNs.</p> <p>During interview with the HR manager it was identified that the facility has a low staff turnover. This was confirmed during staff interviews with staff who have worked at St</p>

Andrews Village from three years to 23 years. The service has a pool of casual staff that covers sick leave and annual leave. If this is not possible a preferred provider is used for replacement staff. These staff have undertaken on-site training and must be approved by the HR manager.

Seven of seven hospital and seven of seven rest home level care residents and three of three family/whanau member interviews confirm their satisfaction with the services delivered and that they have no concerns about staffing levels or skills.

ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The 19 of 19 randomly selected records reviewed (three dementia unit, six rest home and ten hospital records) evidenced well managed integrated records, each with coloured dividers for each section and a health record file order index in line with the InterRAI process. This ensures that all resident's clinical and archived files are kept in the same order/sequence as documented. The two newly implemented consent forms in use for general health care procedures and consent form regarding health information are in each resident's file signed and dated. Additional recognised assessment tools are still retained in the clinical records. The electronic InterRAI comprehensive assessment is printed off and a copy is retained in each record along with the care plans sighted. This system is working effectively and the hospital uses a different care plan which has been approved by the InterRAI advisors. All records sighted are accurate and up to date. All entries by staff are signed and dated clearly and signatures can be verified. Thirty eight medication records

reviewed have photo-identification. All resident records are stored appropriately in locked chart trollies in each service. There is an electronic resident register/database which is maintained daily. Archived records are stored in a dry safe facility which is secure and fire protected and records can be retrieved at any time by management staff when and if required. All resident information is collected and stored in accordance with the NZ Health Records Standard.

ARRC requirements are met.

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

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

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

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

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

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

Criterion 1.2.9.9 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: 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:

Documentation Review: The organisation has a clearly identified process for pre-entry and entry to this service. The requirements for all residents to be assessed prior to admission or transfer to another service is made known to staff. The information pack is provided and pre-entry and entry requirements are highlighted. Entry to all services is facilitated in a competent, suitable and respectful manner.

Hospital, Dementia Unit and Rest Home:

An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the Village. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whānau or representative. The fourteen residents and three family members report that prior to admission meetings are held with the nurse manager (NM) and admissions clerk regarding the admission agreement to ensure they have full understanding of the requirements. The documentation is given to residents and family in two separate packs and follow up is undertaken with them to ensure they understand the information given. The fifteen staff interviewed each have a role which they undertake with new residents (eg, the cook meets and explains the menu).

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:

Documentation Review: Where referral and entry is declined this is documented in the entry to service documentation in relation to the different service provided in this organisation as to how to manage these situations effectively.

The admissions clerk reports this rarely occurs as they have close contact with the ADHB referrers and community nurses. The only reason would be usually a lack of a bed in the required area of care. An enquiry form is completed and held in a folder (sighted).

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:

Hospital

There are numerous policies and procedures sighted that are relevant to service provision for this aged care setting available to guide staff in all aspects of service delivery to ensure residents receive timely, competent and appropriate services in order to meet their assessed needs and desired goals. Policies, procedures and guidelines are available for each stage of service provision including assessment, planning, provision, evaluation/review and or exit from the service to meet timeframes and promote safety when meeting the needs of the residents in all service areas. On admission all residents assessed as hospital level care are seen by the registered nurse allocated who completes the initial assessment. The GP will visit within forty eight hours or earlier if required. The GP has access to all written documentation relating to the resident's admission assessment. The needs assessment co-ordination service (NASC) prior to admission assessment is taken into account by the registered nurse and both assessments are used as the basis for care planning. The registered nurses and the three hospital nurse managers interviewed are very experienced in aged care and have clinical input and support from the two clinical managers. Training records are available and sighted evidencing all education has been well attended.

Ten of ten hospital residents' records randomly selected and sighted evidence resident/family/whanau input is considered. One resident verified that full consultation was sought from the resident and her family when developing the care plan and during the assessment process. A full comprehensive assessment is performed on all individual residents. The organisation is in the process of transitioning to InterRAI for all hospital level residents. All ten records had completed electronic assessments and a copy of the assessment is printed off and kept in the front of each record reviewed. Associated recognised tools are still used as part of the assessment process and retained in the records reviewed. Six monthly multidisciplinary reviews are performed six monthly with family/resident input. The general practitioner and the nurse managers interviewed verified this process. Each stage of service provision is performed by competent and well qualified registered nurses who have either completed (or are in the process of completing) the full training for InterRAI. Only two new staff employed are yet to complete this programme. The two clinical managers are also fully trained. InterRAI will be fully implemented into the rest home and the dementia unit when relevant staff are fully educated for this assessment programme. The care plans are reviewed six monthly or more often if required. All hospital level residents are reviewed by the GP monthly and more often if required. The annual practising certificates for all GPs and the registered nurses have been reviewed. Fifteen clinical staff interviewed verified that team work is promoted and continuity of care is not compromised but encouraged at all times.

ARRC requirements are met.

Hospital Tracer

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

Dementia Unit and Rest Home:

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

Tracer Methodology Dementia Unit:

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

Tracer methodology Rest Home:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Hospital

There are appropriate policies and procedures to guide staff in the full assessments required on admission to this service and during service provision and specifically to the different services provided. The needs assessment service coordinators assessment completed prior to the admission is significant as this is used as the basis of service delivery planning. Additional care related policies are well documented and available. There is clearly set out policy and procedures related to management of challenging behaviour and skin care management. The continence management policies and procedures, clearly states how the programme is coordinated and evidences a continence and product management flow chart on how to meet management goals. The use of recognised assessment tools is acknowledged as good practice management and has been assessed on site. Assessment tools are used for determining falls risk, pressure area risk, wound-care, pain management and continence management. All assessments are retained in the resident's record as well as a copy of the InterRAI assessment. The 10 of 10 records sighted evidenced that assessments are conducted within the specified timeframes. Short term care plans are used for residents as required.

ARRC requirements are met.

Dementia Unit and Rest Home:

The initial nursing assessment includes good use of clinical tools and these include falls risk, pressure area, and mental assessment. Referral letters are sighted from external agencies, including ADHB clinics, and there is evidence of family/whanau involvement in the assessment process. Evidence is sighted in all nine files (three dementia unit and six rest home) reviewed that assessments are conducted within the specified timeframes. The NM reports that a meeting is held with the family and resident four weeks following admission to ensure all the resident's assessed needs are what the family and resident want. This includes discussion of any areas that the resident and family may require further information. The RN and HCA's report they have a discussion regarding all new residents to ensure they have all the information they require to ensure safe service delivery.

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

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: Hospital: In all 10 of 10 residents' care plans are resident focused, integrated and promote continuity of care. There is documented evidence of resident or family/whanau input in the development of the care plan. One resident stated that full consultation and involvement was encouraged when the care plan was developed. Family were involved as well. The care plans reflect clear interventions and the support required being documented to achieve the desired outcomes as identified by the ongoing assessment process. The 10 of 10 care plans are well documented and the name of the registered nurse responsible for the resident is clearly signed and dated. The multidisciplinary approach is observed with input encouraged and this is evident in the assessments and in the integrated progress records sighted. ARRC requirements are met. Dementia Unit and Rest Home: In all nine files (three dementia unit and six rest home) reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and mental capacity. Clinical risk tools are used as part of the intervention process and towards measuring achievement of desired outcomes. All health professionals document in the resident's individual clinical file and have access to care plans and progress notes. Documentation in all nine files (three dementia unit and six rest home) reviewed include nursing notes, medical reviews and hospital correspondence. The NM accompanies the doctor on their rounds and the doctor documents in the residents' notes and the NM in the progress notes. Evidence is also seen of letters from ADHB clinics. The care plan is written in a language that is user

friendly and able to be understood by all staff. This includes the InterRAI documentation in five files. In all nine residents' files (six rest home and three dementia unit) reviewed there is evidence to demonstrate involvement in care planning of the family/whanau.

The nine clinical staff (two NMs, two RNs and five HCA's) report they receive in house education on all the clinical risk tools used as part of the compulsory education hours provided. The three relatives and seven residents report that they are involved with all the care planning and contacted if there are any changes.

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA

Evidence:

Hospital:
In all 10 of 10 hospital records reviewed there is evidence of the interventions relating to the residents' assessed needs and desired outcomes. Interviews with the tracer resident and four of five additional residents and one family member confirm they are satisfied that the resident's needs are being met. Seven healthcare assistants interviewed from both the rest home and hospital care settings in a group interview reported that they are informed of all care plan issues at handover between shifts and handover records are maintained. All have received relevant education. There is adequate continence and dressing supplies available and the registered staff perform all relevant assessments needed. The health care assistants verified that they are consulted when the care plans are being reviewed. In the ten records reviewed evidence was sighted of links with other services on a referral basis. A copy of any referrals is retained in the individual resident's record. Local community agencies visit the facility as required. The education programme is implemented for 2013 and planning is underway for 2014. Staff interviewed (two registered nurses and seven healthcare assistants) express knowledge and understanding of residents' rights, choices and privacy issues. One relative spoken to spoke highly of the care, management and satisfaction with the service the family member is receiving.

ARRC requirements are met.

Dementia Unit and Rest Home:

In all nine files (three dementia unit and six rest home) reviewed there is evidence of interventions relating to the residents' assessed needs and desired outcomes. The nine clinical staff (two NM, two RN's and five HCA) interviewed report they are informed of all care plan issues at hand over and have relevant in-service education if required.

In all nine residents' files (three dementia unit and six rest home) reviewed there is evidence of referrals from the ADHB, including Mental Health Services for the Older Person (MHSOP) and diabetic clinic. The seven residents and three relatives interviewed report that they are satisfied with the external contacts for any health issues and other personnel that are available when required.

The education programme (sighted) implemented at St Andrews Village includes in-service education on diabetes, challenging behaviour and manual handling as part of the compulsory in-service sessions to attend. Evidence is sighted in staff files reviewed and clinical staff interviewed report attendance at the sessions.

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

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

Attainment and Risk: FA

Evidence:

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

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
<p>Evidence:</p> <p>A qualified Diversional Therapist works full time and oversees seven activity coordinator staff who work various hours Monday – Friday. All staff have completed or working towards the dementia units as part of the NZQA National Certificate in the Care of the Older Person. The activity staff rotate every two months to ensure they work in all areas of the facility.</p> <p>There are six separate areas and one main activity room. Each separate areas has individual programmes and the residents are encouraged to attend the main area for special events.</p> <p>Documentation in nineteen files (three dementia unit, six rest home, ten hospital) includes an individual activity plan and is reviewed within required timeframes. In the dementia unit as in all units a “This is your Life” form is completed by family on admission and separate “This is your life” posters are available in the dementia unit. Evidence is seen of yearly planning for all areas and the main activity area. The activity team focusses on an all-inclusive approach to activities. This occurs by inviting friends, family, residents and staff to monthly theme activities. This includes Market Day, Cultural day, mid- winter celebration, and now Christmas themes from 1920-1980.</p> <p>Three initiatives started this year include:</p> <ul style="list-style-type: none"> a) Each activity staff member discussing with the RN if any residents are unwell or may require some one on one time. They document this in a note book (sighted). b) An inventory of all equipment in each area is held and cleaning tasks are undertaken each week to ensure infection risk in reduced. c) Each fridge which contains eggs or any product for baking has the temperature monitored (sighted). <p>An activity statistic form is used to evaluate attendance at activities as a quality improvement project. This has demonstrated that the changes implemented in the activity area over the past 18 months has increased attendance from residents and the six mthly resident surveys also report the changes have received positive feedback.</p>

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:
Finding: Having fully attained the criterion the service can clearly demonstrate a review, analysis and monitoring process related to activity attendance. A quality improvement project has been undertaken which has included the development of an activities statistic form which demonstrates the changes implemented in the activity programme over the past 18 mths has increased attendance. The data from the activities statistics form has been monitored by the diversional therapist and the success of the outcome is measured by the number of residents that attend activities offered. Resident satisfaction with activities offered is confirmed in the resident satisfaction survey and during interview.
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: Hospital: The care plans are evaluated six monthly by the registered nurses as per the review schedule sighted and more often if necessary or the needs of the individual resident changes significantly. Evidence is maintained of the review dates and the name of the person and designation is clearly documented. Input of family/whanau and the multidisciplinary team is evident. The healthcare assistants are also consulted as they are with the residents and provide the day to day cares as needed. The nurse managers in each of the three houses visited discussed the care planning evaluation process. There are ninety eight (98) hospital level care residents at this facility. Three houses accommodate thirty hospital residents each and one further house has a mixture of both rest home and hospital level residents. (Ten rest home, ten hospital, ten swing beds which can be either rest home or hospital. If there is any significant changes the health care assistants report this to the registered nurse and/or nurse manager and the nurse manager contacts the doctor and notifies the family/whanau concerned. Details are clearly documented in the progress records. The care plan is updated with interventions to support the resident towards meeting goals documented. ARRC requirements are met. Dementia Unit and Rest Home:

When a resident has an event that is different from expected, evidence of this is noted on a short-term care plan. This was noted in all nine files (six rest home and three dementia unit) reviewed as is appropriate. This can relate for example, to challenging behaviour, urine and chest infections. If an on-going risk or problem is identified this is then transferred to the long-term care plan. The NM reports she uses the short term care plan and informs staff at handover of the changes and also undertakes relevant education if required. Evidence is seen in the resident's file of a resident with a urine infection. The resident was put on bed rest, given extra fluids and the GP visited and prescribed antibiotics. There is evidence in the files of contact with families regarding service delivery change. The three relatives interviewed report notification of any changes.

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

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

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:

Hospital:
Referral processes are documented and in place to guide staff and examples will be followed during the site audit to ensure residents are supported and referrals are appropriately facilitated to meet the needs of residents receiving services in this organisation. Residents have the option to use their own GP or one of the four resident doctors. Referrals to other providers is evident in the ten hospital resident records reviewed mostly for ongoing specialist assessments. Transport is provided for residents to attend external appointments in the community as required. Family/whanau are always given the first option to transport their family/whanau member to external appointments. The geriatricians from ADHB often come to the hospital if ongoing re-assessments are required and especially if the resident is frail. If a resident wishes to change facilities to another health and disability service the NASC service is contacted and the service provider assists as much as possible with arranging the transfer once approved by the NASC service co-ordinator concerned.

ARRC requirements are met.

Dementia Unit and Rest Home:

Residents admitted to St Andrews Village are given the choice of retaining their own GP or using one of the GPs contracted to the facility. The facility has five GPs who are contracted. One of the GPs was available for interview during the audit and has no concerns relating to the care at St Andrews Village. The seven residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. The NM reports that residents are given the choice of changing facilities if they are not happy and also if their health needs change.

Documentation is sighted of a recent transfer of a resident to ADHB for a chest infection. The resident was kept informed and his family contacted.

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:

Hospital
Appropriate policies and procedures are provided for transition, exit, discharge or transfer from the services provided for residents ensuring safety is paramount and who to contact is detailed. The nurse managers interviewed verified the process for transfer to ADHB. The 'yellow bag/envelope' system used by the ADHB continues. This usually arises as an emergency which is co-ordinated by the registered nurse in charge and with the family/whanau and GP. The GP rings the direct line to the registrar health services for older people to discuss the transfer. Once authorised the transfer details is completed with all relevant information being provided to the receiving hospital. Any risks or alerts are identified. A copy of the medication sheet is attached and/or placed in the yellow transfer envelope. Family are contacted. Transportation is arranged safely. Family can escort the resident or a staff member if required.

ARRC requirements are met.

Dementia Unit & Rest Home:

The NM or delegated person, is responsible to ensure that residents are referred to appropriate external services and the transfer process is within policy requirements regarding safety and risk management. Evidence is seen in three of the nine files reviewed of residents who require transferring to hospital in the past 12 months.

Clinical staff report they are aware of the requirements for resident transfer and work with the NM or RN to ensure this is a safe process for the resident.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review:

There are clearly documented policies and procedures documented and implemented for medication management. There is a separate medication manual available accessible in hard copy and electronically for all staff. All policies have been reviewed, are up to date and signed off by the Chief Executive Officer or Clinical Managers for this organisation. The pharmacy service is outlined clearly and all approved abbreviations are documented. The medication management system policies and procedures are numbered and indexed appropriately that cover all aspects of medication management inclusive of guidelines and legislative requirements being clearly referenced and met. A medication management policy is documented and refers to the processes to be used to prescribe, dispense, administer, review, store, dispose of medications.

Hospital, Dementia Unit and Rest Home:

Each resident's allergies are established during admission assessment and documented in the medication administration chart. Any allergies or sensitivities are clearly noted on the medication administration chart. If no allergies are known then this is documented to identify that it has been checked. The standing orders are up to date and comply with legislative requirements.

There are Controlled Drugs kept in all areas except the Dementia Unit. They are kept in a locked cupboard accessible when required. A Controlled Drug Register is available and controlled medications processes are up to date. The robotic rolls are delivered monthly or earlier if required and each are checked to ensure they are correct with the medication sheet. Evidence is seen of a separate signing sheet for RNs to sign when checking rolls on arrival.

The process for reporting medication errors or omissions is detailed within the policy. The process for identifying residents and administering medications is detailed along with documentation responsibilities and this becomes part of the quality improvement programme.

If a resident chooses to self-medicate they may do so if assessment (a template is provided) shows that they are capable to do this. The NM assesses a resident's ability to take their own medication with the GP at least every 3 months or when their physical or cognitive state changes. Self-administration of medication must be noted on the resident's care plan. There is one resident self-medicating on the day of the audit and all requirements are met. Controlled medicine is not self-administered.

There are staff competency assessment processes for oral and other medications, insulin, other injections and warfarin. The NM and RN's all hold IV certificates (sighted). Registered nursing staff and qualified health care assistants responsible for medicine management have an annual competency review prior to administering medicines. The RN and health care assistants in all areas are observed during the lunchtime medicines round and correct procedures are followed. Completed assessment forms are seen of health care assistant competent to give medication on the day of audit. All fourteen residents spoken with, report the GP discusses their medicine requirements.

All 38 medication sheets reviewed contain all aspects of the requirements of the medication management policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The food service policies and procedures are available and implemented by the contracted food service provider. The food service manager has been at this facility for five years. The food service manager interviewed is totally responsible for the service and all reporting foremost to the contracted management team as required and to the SAV support services manager. All paperwork and reporting is submitted electronically to the contracted management. Guidelines are used that provide nutritious and appropriate meals for aged residents. The menu plans are summer and winter and are six weekly planned and cycled. The contracted service has their own dietitian who is responsible for the reviewing of the menu plans. A letter is available verifying the audit dates and the areas requiring improvement. Recommendations were provided as corrective actions. The next audit is due dated 31 March 2014 as this is the expiry date documented. The food service manager is responsible for two senior chefs, one cook, three kitchen hands and three late shift employees. All staff are fully trained to meet the food service NZQA 167. The head office trainer comes to SAV two sessions annually to train staff. During the assessment process the registered nurses should they identify any specific nutritional needs for residents when undertaking the nutritional status assessment report this to the food service manager. A copy of the assessment retains in the file and the other goes to the kitchen staff. Any special diets or likes and dislikes are documented onto the whiteboard in the kitchen. The foodservice manager has the birthday list displayed and a cake is made for all birthdays in any one month. Any other special days or theme days are celebrated as part of the activities programme. Food is prepared to fit the occasion. A list is made up daily of any special instructions, preferences, types of meals, size of portions to guide the cooks.

The food services manager interviewed explained the procedure for food procurement, production, preparation, storage, transportation, delivery and disposal of waste and meeting legislative requirements. All food ordering and supplies is completed by the food services manager. A list of preferred suppliers is sighted. One main supplier is evident and all foods delivered are checked before being put stored appropriately. There is a large pantry with emergency supplies as well, two deep freezers, two walk in chillers, one full store, one day store, one chemical store which is locked at all times. All fridges and chillers are temperature monitored daily and records are available and sighted and are monitored accurately. The kitchen has a good flow from dirty to clean areas. The waste is collected on a Thursday by the council. The meals are delivered to the houses in trollies divided into hot and cold meals and are given out by the staff in each house in the dining room. One resident interviewed was eating more now that the resident is feeling more settled in. The meal at lunchtime was well presented to meet the individual needs of each resident. The staff fed the meals to residents unable to feed themselves. Additional supplements can be arranged and provided if residents are not eating very much. The dietitian is able to approve Ensure and other high calorie supplement drinks if required.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: CI

Evidence:

Documentation Review: There are policies and procedures for the management of waste and hazardous substances. Staff are provided with personal protective equipment (PPE) and resources in all of the service areas. The organisations policy identifies that the service will comply with the Health and Disability Sector Standards and the Auckland District Health Board agreement, the Code of Health and Disability Services Consumers` Rights 1996 and local authority requirements. The CEO is responsible for the Health and Safety Programme delegating operational management to the manager and the health and safety co-ordinator. Storage of waste and hazardous substances will be observed on the site audit. Detailed procedures relating to incidents or accidents are included in the health and safety and infection prevention and control policies and any incidences would be reported immediately to management. The organisation has an emergency plan, incident accident policy and fire safety policies are available and all have been reviewed.

Stage two: Chemicals are supplied by an approved supplier who ensures safety data sheets are kept up to date. As sighted information about chemicals is in all areas chemicals are located. Chemical storage areas are well labelled and very well secured.

As confirmed by the support service manager, there are no specific territorial authority requirements for waste disposal. St Andrews undertakes appropriate storage and disposal of waste, infectious and/or hazardous substance to comply with current legislation. The service has undertaken a project related to improving the way they manage separation and disposal of waste products. Documentation and observations made show that waste care management has fully attained the criterion 1.4.1.1. and the service can in addition clearly demonstrate that review and analysis of each step of a project has been undertaken to create a safer, more efficient separation and disposal of waste products. This has gained a continued improvement rating. Cleaning, maintenance, and clinical staff and management report that the project is very successful and that everyone has contributed to the success of the project.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons, goggles and masks. Interviews with 24 of 24 staff from across the organisation plus two contracted cleaner staff, confirm they can access PPE at any time and they can verbalise appropriate use. The service uses disposable glove holders which are wall mounted so they can be pulled down from the box rather than pulled out of the box to meet current good infection control practice. Staff is observed wearing disposal gloves and aprons as required.

Approved yellow sharp bins sighted are used for the safe disposal of sharps. Sharps bins located in all the medication rooms.

ARRC requirements are met.

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

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

Attainment and Risk: CI**Evidence:**

Staff interviews confirm their knowledge, understanding and implementation of newly updated policies and procedures. This is confirmed in audit results sighted.

All chemicals are securely stored and safety data sheets are available. There are no specific territorial authority requirements for waste disposal.

The service has undertaken a project related to improving the way they manage and dispose of waste products. Documentation and observations made show that waste care management has fully attained the criterion 1.4.1.1. and in addition demonstrates the project includes analysis and reporting of improved outcomes following each step. This project is being led by the infection control team with input from all staff. It is fully supported by the senior executive management team.

To date the project includes:

- a review and update of waste management policies and procedures
- staff education and monitoring of implementation of policy to include written instructions and pictorial evidence of what goes into each bin
- the relocation of waste management bins to designated areas around the site
- obtaining more waste management bins
- waste segregation information including coloured posters and written material being provided to all areas of the facility
- the nomination of a waste management project coordinator
- more regular auditing to inform the results of each stage of the project.

The project occurred as the result of a waste management audit undertaken in September 2013. The audit shows that waste material was being put in the wrong bins and the yellow medical waste bins were being used for all rubbish not just medical waste. All the rubbish bins were being over filled. This project was led by the infection control team and involved all staff from all areas of the service including contracted cleaning and kitchen staff. The corrective actions taken resulted in clearer written instructions related to waste management being included in the infection control programme; small clearly labelled recycle bins being placed in all areas including clinical nurses stations along with coloured posters showing what goes in each bin for example green bins for biodegradable waste, yellow bins for medical or contaminated waste and red bins for security document control.

The project is fully supported at senior management level and sponsored by the support service manager who ensured memos were sent to staff to keep them informed throughout the process.

Finding:

Having fully attained the criterion the service can in addition clearly demonstrate that review and analysis of each step of a project undertaken related to safer, more efficient separation and disposal of waste products. The findings from a September 2013 audit are written up as corrective actions and owing to systemic nature of the problem developed into a major project. The corrective actions taken resulted in clearer written instructions related to waste management being included in the infection control programme.

Documentation and data sighted related to the project identifies that the waste management processes have been re-audited in October and November 2013 and results show that compliance and staff understanding of policy has increased from 33% to 100% resulting safer, environmentally friendly practices being undertaken.

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

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

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

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

Standard 1.4.2: 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:
Documentation Review: The organisation has policy in place in relation to transportation of residents.
Stage two: All processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 30 June 2014. There are well documented regular and long term maintenance schedules and plans. A team of maintenance workers ensure that reactive maintenance is undertaken promptly as evidenced in work sheets sighted. All requested maintenance jobs are signed off upon completion and timeframes are monitored and overseen by the property services manager.
Electrical testing occurs throughout the year and all electrical appliances are tested prior to use at the facility. This includes new equipment and resident equipment. Members of the maintenance team are approved to undertake the test and tag electrical safety testing.

All biomedical and medical equipment which includes beds, hoists, otoscope, oxygen connectors and regulators, sphygmomanometers, stethoscopes, syringe drivers and chair scales had safety checks and were calibrated by an approved provider in November 2013. Items which fail the test and calibration are removed and either repaired or replaced. This is well documented. All equipment is identified in the asset register sighted.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. Wide corridors with safety handrails assist residents to mobilise safely. Residents who have mobility difficulties are assessed by a physiotherapist and appropriate walking aids are obtained to assist with safe mobilisation.

Over the past few years the service has installed ceiling hoists in 43 of the 100 hospital resident bedrooms. This is an ongoing quality improvement and more ceiling hoist will be installed over time, beginning with five more to be installed in January 2014. There is a company contracted to test all lifting slings for both portable and fixed hoists to ensure they are in safe working order.

Regular environmental audits are undertaken and corrective actions are documented for areas that have a deficit identified. The maintenance book and interviews with staff (including the maintenance staff) and residents confirm repairs are undertaken as soon as possible. Monthly maintenance checklists sighted are up to date.

Residents have access to well-maintained outdoor areas with seating and shaded areas. There is a secure outdoor area for residents located in the dementia unit. Interviews with 14 of 14 residents (seven hospital and seven rest home) and three of three family/whanau members confirm the environment is suitable to meet their needs. Residents were observed walking around inside and outside the facility both independently and with the use of walking aids.

ARRC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

The Lodge which is a detached older building that houses 30 rest home level care residents has bedrooms with toilet and hand basins and shower areas are centrally located throughout each wing. There are privacy locks on the doors to ensure privacy when undertaking personal cares. All other areas have full ensuites in each bedroom which are large enough to allow staff to assist residents as required. Sanitising hand gel is available throughout the facility.

Hot water temperatures are monitored and recorded and if it goes over the required 45oC in a resident area it is regulated and rechecked. This process is undertaken by the maintenance team who record all actions. Documentation sighted shows that one area had no follow actions taken when the hot water temperature reached 48oC. The maintenance manager said that follow up actions were taken but not documented. The area was checked on the day of audit and hot water temperatures were below 45oC. This is not systemic as other recordings identified the actions taken.

There are separate staff and visitor toilets throughout the facility.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

All bedrooms are single occupancy. They are personalised to meet residents' wants and needs and are large enough to allow residents with or without mobility aids to move around safely.

Ten bedrooms which were approved to have either rest home or hospital level care residents in September 2012 are suitable for this purpose. The facility is very well equipped and lifting equipment is readily available as required. All bedrooms in the main facility (this excludes the Lodge which is a dedicated 30 bed rest home area and is a separate building) have extra wide doors to all ease of bed movement if required.

Interviews with residents and family/whanau confirm they are happy with their bedrooms and that they can personalise the area. This was observed on the day of audit. In the dementia unit bedroom doors are kept locked when the residents are not using them to ensure the security of their personal items. Residents who wish to be in their bedrooms are able to do so.

ARRC requirements are met.

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

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuver 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:

Stage two: The physical environment provides safe, age appropriate and accessible areas to meet resident's needs. Rest home and hospital level car residents are free to move around the facility as they wish. Dementia care residents have secure indoor and outdoor areas where they are free to wander as they wish.

There are separate dining and lounge areas in all areas to provide for residents relaxation and dining needs. Activities are undertaken in all areas as appropriate to the activity. There are small, appropriately furnished seating areas throughout the facility. All areas are furnished to a high standard.

Fourteen of 14 residents (seven hospital and seven rest home) and three of three family/whanau interviews confirm their high level of satisfaction with the facilities provided.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: There are adequate and comprehensive policies and procedures related to the cleaning and laundry services and management available and these have been reviewed. Processes are clearly defined to guide staff providing these services. Manuals are available and accessible to all staff. The cleaning and laundry procedures are audited and products used for effectiveness. All cleaning schedules are available and have been sighted.

Stage two: Laundry processes are undertaken as described in policy and according to the job description sighted. Cleaning services are contracted. The laundry is well equipped and has recently been refurbished. It has an excellent clean/dirty flow. Daily water temperature forms sighted and effective detergent titration levels are monitored by an approved company to ensure the effectiveness of each wash cycle. All laundry equipment is on a regular maintenance programme undertaken by the company who manufactures the equipment used. The service support manager is currently undertaking a project related to maintaining the water temperature during the entire wash cycle.

There are dedicated cleaning and laundry staff, seven days a week. Interviews with cleaning and laundry staff confirm they have adequate supplies of personal protective equipment and they verbalised their knowledge related to when to wear gloves and aprons. PPE is sighted in all areas. Staff verbalise their understanding of isolation techniques and knowledge of documented laundry and cleaning process related to outbreak management.

The chemicals used in the facility have safety data sheets displayed and are available to all staff. Staff education is confirmed during interview and in the staff file reviews undertaken for the laundry staff members. All chemicals sighted are appropriately labelled.

Cleaning trolleys are securely stored when not in use.

Interviews with residents and family/whanau confirm they are satisfied with laundry and cleaning services.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: The organisation has a documented emergency and disaster plan in place as per the Health and Safety programme.

Stage two: The approved emergency evacuation plan signed off by the New Zealand Fire Service is dated 02 June 2006. There have been no changes to the facility footprint since this time. Six monthly trial fire evacuations are conducted. Last undertaken on 21 October 2013. Staff education records identify that staff attendance at trial evacuations and fire training is closely monitored by the HR department. Fire and emergency training is included in staff orientation and regular on-going sessions are undertaken throughout the year. The emergency manual sighted was updated in March 2013.

Fire equipment was checked by an approved provider in May 2013. Records are sighted for regular sprinkler, fire doors, emergency lighting and sign checks as required to meet building warrant of fitness requirements. The sprinklers are connected to the fire service and the smoke detectors are connected to fire mimic panels located outside the door of each house. There are manual fire alarm points throughout the facility and in the dementia unit they have tamper prevention covers to discourage residents from pushing the button.

Civil defence and emergency supplies are checked every quarter. The service ensures there is emergency food and water for a minimum of three days. Food is rotated to ensure it is used within best before dates. The emergency water tanks (two 25,000 litre tanks) have pumps which operate if the water pressure drops. There are three emergency generators on site one operates all administration equipment, such as computers and the telephone system, and the other two ensure the kitchen and laundry services and that emergency lighting is maintained in resident areas in case of an emergency.

There are only five staff that do not hold current first aid certificates. All clinical staff certificates are current and this ensures there is always a staff member on duty in case of an emergency.

Staff are required to ensure doors and windows are securely closed at night. There is an approved security company who undertakes three nightly random checks of all buildings and the grounds. This service uses satellite monitoring to show which areas are checked. There is CCTV around the grounds which can be monitored as required. The secure dementia unit has a double entry cubicle to avoid residents being able to exit the facility easily.

Call bells are sighted in all resident areas. Call bell response time is monitored to ensure staff respond within an accepted timeframe. Interviews with seven of seven hospital and seven of seven rest home residents and family/whanau members confirm staff respond quickly when the call bell is activated.

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

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

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

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

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

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

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

Standard 1.4.8: 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 resident areas have adequate natural light, safe ventilation and are appropriately heated throughout the year. Ventilation is maintained by the opening of doors and windows. This is confirmed during resident and family/whanau interviews and observation on the days of audit.

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint policy and procedures cover all aspects of this standard. Policy states at St Andrews Village staff minimise the use of restraint and ensure that if restraint is necessary, the aim is to keep the resident safe from harm, from themselves and others and that the practice occurs in a safe and respectful manner. The policies and procedures are based on the Restraint Minimisation and Safe Practice Standard NZS 8134.2008. There are clear definitions of restraint and enablers. Processes are documented should restraint be considered inclusive of restraint assessment, consent obligations, monitoring, evaluation and review. Restraint training and education is a requirement and the obligations are documented. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident independence and safety. The restraint co-ordinator, an experienced nurse manager, maintains accurate and up to date records and oversees the use of restraint and enabler use for five dwellings totalling one hundred and eighty beds (180) of which one hundred and seventy five beds (175) are currently occupied. Currently twelve residents are using enablers across all services for safety purposes. All details are clearly documented on the restraint register sighted. Padded bedrails are the form of enabler used. A brochure 'Restraints and Enablers: Information for families' is given to all family members when restraints or enablers are being considered for a resident. Minutes of restraint meetings are documented with good representation from staff attending the meetings. Each area of service has a restraint representative and they attend the restraint committee meetings.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA

Evidence:

There are clearly documented policies and procedures for restraint approval and processes which outline clear lines of accountability for restraint use. All policies and procedures have been reviewed. The restraint co-ordinator interviewed is very well informed of the processes in place for determining approval of all types of restraint used, duration of restraint use and ongoing education is provided to staff. Restraint is part of the mandatory training for new staff orientation and education is ongoing. The general practitioner interviewed is responsible for the approval of restraint for the residents in care and there are three other GPs available and who are responsible for approval for their respective residents should a restraint be required. Forms sighted have been signed and dated and the restraint register sighted is updated with when a restraint started, date restraint last reviewed and the actual restraint review date. The house, name of the individual resident, type of restraint or enabler is also documented on the restraint register maintained. Numbers of restraints and enablers in use can easily be collated from this clear and distinct information.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The restraint co-ordinator interviewed explained the comprehensive assessment undertaken and demonstrated the forms completed and the requirements in relation to use of restraint. A pre-assessment is performed to ensure other strategies have been trialled before the decision to use a form of restraint is made. Any de-escalation techniques are tried for residents presenting with challenging behaviour. Staff education records demonstrate that 93% of staff have attended de-escalation training and managing behaviour in-services arranged by the restraint co-ordinator. Staff interviewed seven healthcare assistants and three nurse managers one of whom is the restraint co-ordinator are well informed of using restraint only as a very last resort and all methodology is used before hand to endeavour to manage the resident effectively. Family/whanau are kept well informed as are the medical staff. Twenty two residents are using restraint, such as 'fall out' chairs and/or lap belts. There are two residents in the dementia unit house five, who have to have personal restraints to assist for meeting hygiene needs, only as a last resort, and this is carefully documented when and if required and documented on the restraint register clearly. One resident in house three is also requiring additional assistance to meet personal care outcomes when and if required and this is documented on the restraint register sighted.

Individual resident records reviewed evidence a thorough assessment, that the doctor has documented his/her final decision, and the reason for the use of a restraint and/or an enabler. Consent is signed by the resident/EPOA, consent form signed by the RN/NM and that the restraint /enabler is discussed and reviewed at the six monthly review meeting and options to avoid ongoing use of the restraint were considered and documented. Records were audited for compliance and the audit results were available to sight and the service meets all compliance requirements.

The ARRC requirements are met.

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

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

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

Attainment and Risk: FA

Evidence:

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

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

Services use restraint safely

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

Attainment and Risk: FA

Evidence:

Restraint is only used as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. Safety is paramount and the co-ordinator and staff interviewed are fully informed and appropriate monitoring is set up for the resident for this reason to monitor safety. The monitoring of restraint forms are kept at the nurses station' in each house to evidence the residents on restraint use/enabler use are appropriately released from restraint/enabler every two hours and their position changed.

The restraint co-ordinator and approval committee are all health professionals who are very experienced and able to make informed decisions in the interest of resident safety. The type of restraint is decided upon to meet the needs of the individual resident and to promote safety as a last resort only and this is clearly understood by the health professionals, such as the clinical manager, the restraint co-ordinator and the general practitioners involved with the individual resident. All stages are clearly documented and can be followed through accurately.

Input from family/whanau/representative is evident and all signatures and dates are documented on the specific forms developed and implemented for this organisation. Advocacy and cultural needs are respected by staff interviewed and included in the assessment and care planning reviewed. Monitoring forms are reviewed and kept when completed in the individual resident's record.

ARRC requirements are met.

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

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

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;

- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

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

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

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

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

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

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

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

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

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA
Evidence: <p>Full evaluations are performed three monthly to ensure each restraint is evaluated in collaboration with the resident to ensure the following forms are sighted such as all of restraint documentation, entire care plan including mobility wall chart and signed consents. Any outstanding actions are completed in one week if found. Any issues or recommendations for improvement are also recorded. The restraint co-ordinator provided evidence of restraint/enabler best practice audits which are performed three monthly before the six monthly care review meeting. The audit is completed by the restraint representative in each of the five houses who have a restraint/enabler in use. Once the audit is completed it is given to the restraint co-ordinator and the quality co-ordinator to analyse and evaluate the results. Results are fed back to the care review meetings. Minutes are sighted for 6 August 2013 and 8 November 2013. Cultural recognition associated with restraint use, resident assessment, monitoring restraint enabler use and emergency restraint use if required are all audited. The services have a high compliance rate which was demonstrated and reviewed. The register is also reviewed for accuracy and all documented requirements are up to date.</p> <p>ARRC requirements are met.</p>

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

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

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

From the audits performed three monthly any issues or corrective action requests are reported for quality improvement. Any areas of non-compliance is documented clearly with the locality and details found in the documentation. The list of corrections/quality improvements required are highlighted with how this can be improved or rectified; was the corrective action/quality improvements achieved (yes/no); and the restraint co-ordinator signs off if this is achieved or ongoing. When closed off the clinical manager is responsible for closing this off. One of the clinical managers is the restraint adviser for this organisation. The audit forms and outcomes sighted are dated 20 November 2012 and 22 August 2013. No trends were identified but minor details around documentation were noted for improvement.

ARRC requirements are met.

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

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

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

Attainment and Risk: FA

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:

Documentation Review: The responsibility for infection control is clearly set out in the infection control manual. An infection control nurse is appointed to this role and has a job description. The infection control governance policy includes the terms of reference for the committee which identifies that accountability is directly to the CEO. The organisation has a clearly set out infection control programme that is reviewed annually. The infection control programme has links with the risk management programme implemented by the organisation and is approved. There is a defined process for gaining advice and support as required. A designated infection control committee is established and is led by the infection control nurse/co-ordinator. The terms of reference for the infection control committee clearly state the role it is to undertake.

Hospital, Dementia Unit and Rest Home:

St Andrews Village infection control programme identifies that the IPC programme is developed by the NM/IPCC alongside six other RN's who are responsible for IPC in each area. Evidence is seen of the programme being reviewed at least annually. The programme is evaluated to assess the progress in achieving the 2012 goals and objectives and establish priorities for 2013 (evidence sighted).

The roles and responsibility for the infection control coordinators is defined in a position description (sighted). Fifteen of the fifteen staff interviewed confirm that they are required to report residents who are suspected of having infections to the NM promptly. All staff interviewed are able to identify the importance of hand hygiene and using standard precautions.

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Documentation Review: The infection control committee consists of a broad cross section of staff with varying specialist skills and expertise. The terms of reference identifies that the infection control committee facilitates the implementation of the infection control programme.

Hospital, Dementia Unit and Rest Home:

In the case of an outbreak, advice will be sought from the GP, laboratory services and experts at the ADHB. The IPCC/NM is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.

Evidence is sighted of an outbreak of Norovirus in 2012. This was contained in the Dementia Unit and the report showed the procedures taken to ensure there was no further spread in the facility. This included separate laundry and dedicated staff to the area.

Education is also provided by the nurse specialist at ADHB and staff are given the opportunity to attend these in-services. The fifteen staff interviewed report good knowledge of infection control, standard precautions and outbreak management. The seven residents and three families are informed of any infections and notices are put on the door when required.

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:

Documentation Review: Policies and procedures comply with relevant legislation and current accepted good practice. Policies and procedures sighted cover all requirements to meet this standard. Policies and procedures are consistent with infection control principles. Review is part of the terms of reference for the infection control committee to be overseen by the infection control nurse/co-ordinator/NM

Hospital, Dementia unit and Rest Home:

The fifteen clinical staff (four NM, nine HCA, and two RN) report they are informed of any policy changes as part of the education programme. They are also given the opportunity to attend ADHB in-service education on Infection Control. The NM/IPCC attends the IPC conference annually or when it is held.

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:

Hospital, Dementia Unit and Rest Home:

Staff orientation covers infection control education relevant to practice within the organisation. Infection prevention and control education was provided to all staff in 2012 and 2013. This included standard precautions and management of incontinence. A record of attendance is maintained and a copy of the presentations held on file (sighted). Fifteen of the fifteen staff interviewed confirm attending these in-service educations. The education plan for 2013 is sighted and includes infection control sessions.

Education is provided to residents (and/or family members) related to hand hygiene and isolation, if there is an infection outbreak. This is confirmed in interview with residents and families members.

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Hospital, Dementia unit and rest home: The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Policy states that surveillance shall be conducted on antibiotic use. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy. Policy states that surveillance will be presented at quality and staff meetings. An annual summary of the number and type of infections per month is maintained and sighted for 2013.</p> <p>A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. The urinary tract infection (UTI) data is imputed into the computer each month and reports surveillance data at monthly quality meetings. The data is benchmarked against national data monthly. The NM/IPCC reports there was an outbreak of Norovirus in 2012 and the correct processes were implemented to contain the virus.</p> <p>Evidence sighted of surveillance data from the initial completion of the infection notification form and the process that this becomes part of the quality system. Staff report they are notified of any infections at handover and families are contacted.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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