# Summerset Care Limited - Summerset Falls

## Current Status: 14 January 2014

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

## General overview

Summerset Falls provides rest home and hospital level care for up to 41 residents with eight continuing care apartments able to be used for rest home care. On the day of the audit there are 28 residents including 15 residents requiring rest home care and 13 residents requiring hospital level care. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager who is an experienced manager of health services. The village manager is supported by the nurse manager who has over 19 years’ experience in aged care.

Improvements are required to the following: the quality programme, care planning, medication, safety of residents and restraint.

## Audit Summary as at 14 January 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 14 January 2014

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

### Organisational Management as at 14 January 2014

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 14 January 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 14 January 2014

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Restraint Minimisation and Safe Practice as at 14 January 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk |

### Infection Prevention and Control as at 14 January 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

## Audit Results as at 14 January 2014

### Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family.

There are policies around cultural sensitivity and appropriateness with links to a kaumatua when required and access to spiritual services.

Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.

Residents and family interviewed praised the support and care provided.

### Organisational Management

Summerset Falls has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions.

The quality, management and resident/family meetings serve to communicate any quality improvements. A staff meeting is held.

New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are nurtured into the position.

There is a documented and implemented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day with an on call system in place.

Improvements are required to the quality programme (documentation of resolution of corrective actions, documentation of staff meeting minutes, use of benchmarking data to improve quality of the service).

### Continuum of Service Delivery

The service has assessment process and residents needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are improvements required around care plans, appropriate interventions and wound management. There is a recreational therapist and programmes running that are meaningful and reflect ordinary patterns of life. There are also twice weekly outings into the community and significant input from community groups.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are improvements required around medication management.

Food services policies and procedures are appropriate to the service setting. The food service is contracted to an external provider. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report that individual preferences are well catered. Additional snacks are available if the kitchen is closed.

### Safe and Appropriate Environment

Summerset Falls includes a purpose built rest home/hospital continuing care unit. A code of compliance and compliance schedule is documented and current.

There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose with the property manager and village manager providing oversight of the environment.

There are documented policies and procedures for the cleaning and laundry services and for essential, emergency and security services.

An improvement is required to ensuring that safety of residents is considered with reference to the river to the rear of the property which is currently not fenced.

### Restraint Minimisation and Safe Practice

There are documented policies and procedures around restraint use and use of enablers. Currently there are seven residents using restraint/enablers.

Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.

Improvements are required to documentation of the use of restraint and enablers.

### Infection Prevention and Control

There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. The nurse manager provides support from a clinical perspective. Infection control training is provided to staff at least annually and all staff have completed orientation and training around infection control since they started.

There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed.

The infection control coordinator has access to the nurse specialist District Health Board, general practitioners and other specialists as required.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## 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

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| --- | --- |
| **Legal entity name:** | Summerset Care Limited |
| **Certificate name:** | Summerset Care Limited - Summerset Falls |

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

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| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Summerset Falls | | | |
| **Services audited:** | Hospital services – geriatric services; Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 14 January 2014 | **End date:** | 15 January 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 28 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 9 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 25 | Total audit hours off site | 12 | Total audit hours | 37 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 9 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 48 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## Declaration

I, XXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited 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) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Thursday, 13 February 2014

## Executive Summary of Audit

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| **General Overview** |
| Summerset Falls provides rest home and hospital level care for up to 41 residents with eight continuing care apartments able to be used of rest home care. On the day of the audit there are 28 residents including 15 residents requiring rest home care and 13 residents requiring hospital level care. There is a retirement village attached as part of the complex with overall management of the site provided by a village manager who is an experienced manager of health services. The village manager is supported by the nurse manager who has over 19 years’ experience in aged care.  Improvements are required to the following: the quality programme, care planning, medication, safety of residents, restraint. |

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| **Outcome 1.1: Consumer Rights** |
| Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services is available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Care plans reflect the resident and family values as confirmed through interviews with residents and family.  There are policies around cultural sensitivity and appropriateness with links to a kaumatua when required and access to spiritual services.  Complaints processes are implemented and complaints and concerns are actively managed with evidence of resolution of issues raised.  Residents and family interviewed praised the support and care provided. |

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| **Outcome 1.2: Organisational Management** |
| Summerset Falls has a quality and risk management system that includes documented policies and procedures, review of incidents and complaints, satisfaction surveys, risk management and implementation of an internal audit schedule that includes documentation of corrective actions.  The quality, management and resident/family meetings serve to communicate any quality improvements. A staff meeting is held.  New staff complete an orientation/induction programme and caregivers state that this includes a buddy system to ensure that they are nurtured into the position.  There is a documented and implemented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day with an on call system in place. Improvements are required to the quality programme (documentation of resolution of corrective actions, documentation of staff meeting minutes, use of benchmarking data to improve quality of the service). |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has assessment process and residents needs are assessed prior to entry. There is a well-developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Service delivery plans are individualised. Short term care plans are in use for changes in health status. There are improvements required around care plans, appropriate interventions and wound management. There is a recreational therapist and programmes running that are meaningful and reflect ordinary patterns of life. There are also twice weekly outings into the community and significant input from community groups.  There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. There are improvements required around medication management.  Food services policies and procedures are appropriate to the service setting. The food service is contracted to an external provider. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report that individual preferences are well catered. Additional snacks are available if the kitchen is closed. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Summerset Falls includes a purpose built rst home/hospital continuing care unit. A code of compliance and compliance schedule is documented and current.  There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose with the property manager and village manager providing oversight of the environment.  Documented policies and procedures for the cleaning and laundry services and for essential, emergency and security services.  An improvement is required to ensuring that safety of residents is considered with reference to the river to the rear of the property which is currently not fenced. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are documented policies and procedures around restraint use and use of enablers. Currently there are seven residents using restraint/enablers.  Staff training around the use of restraint and enablers is provided and staff interviewed understand the philosophy of minimal use.  Improvements are required to documentation of the use of restraint and enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| There are infection control policies that are implemented with a registered nurse identified as the infection control coordinator. The nurse manager provides support from a clinical perspective. Infection control training is provided to staff at least annually and all staff have completed orientation and training around infection control since they started. There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed.  The infection control coordinator has access to the nurse specialist District Health Board, general practitioners and other specialists as required. |

## Summary of Attainment

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 43 | 0 | 4 | 3 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 7 | 3 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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. | PA Low |  |  |  |
| 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. | PA Low | (i)Staff meetings are sparsely minuted and do not include all aspects of the quality programme. (ii) The quality meeting minutes consistently state that benchmarking data should be provided however this has not been tabled in any meetings. | (i)Document staff meeting minutes and include all aspects of the quality programme. (ii) Use benchmarking data to improve quality. | 90 |
| HDS(C)S.2008 | Criterion 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. | PA Low | There is limited evidence of resolution documented against corrective actions. | Document evidence of resolution of corrective actions. | 90 |
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Four of six files sampled do not include interventions for all identified areas of need. Examples include weight loss, continence and risks associated with the use of a bed rail. | Ensure that care plans include interventions for all identified areas of need. | 60 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i)One resident has a food and fluid chart that has not been completed to show an accurate portrayal of the resident’s intake. (ii) One resident has been identified as requiring fortnightly weighs following weight loss and these have not occurred. (iii) One resident who has multiple falls has had two falls with head injuries. One of these falls required hospitalisation. Neurological observations were not completed for either of these falls. (iv) Eleven of the 14 wounds have not been reviewed in the stated timeframe. For most wounds the gap is three to five days but for one wound the gap is 11 days and for another nine days. | (i)Ensure food and fluid charts are accurately completed. (ii) Ensure weights are completed as required. (iii) Ensure neurological observations are completed for falls with a potential head injury. (iv) Ensure wounds are reviewed within stated timeframes. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i) On three of 12 medication charts there are PRN medications charted that do not document an indication for use. (ii) A further three of 12 medication charts sampled have regular non packaged medications that are not always signed as administered as prescribed. (iii) Weekly stocktakes of controlled drugs have not always occurred. | (i)Ensure PRN medications document an indication for use. (ii) Ensure medication charts medications are administered as prescribed. (iii) Ensure weekly controlled drug stocktakes occur. | 30 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Four of the eight registered nurses do not have medication competency assessments | Ensure all staff who administer medications have a medication competency assessment. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The river is unfenced and poses a risk to confused wandering residents. | Ensure that all residents continue to be safe at all times. | 60 |
| HDS(RMSP)S.2008 | Standard 2.2.2: Assessment | Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | There is no documentation of consideration of alternatives to the use of restraint as part of the assessment process, assessment of risk related to each restraint, if the resident has used restraint in the past, relevant history, desired outcome and criteria for ending restraint and possible alternative interventions and strategies in the two files reviewed where the residents have both restraint and enablers used. | Document consideration of alternatives to the use of restraint as part of the assessment process, assessment of risk related to each restraint, if the resident has used restraint in the past, relevant history, desired outcome and criteria for ending restraint and possible alternative interventions and strategies. | 90 |
| HDS(RMSP)S.2008 | Standard 2.2.3: Safe Restraint Use | Services use restraint safely | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | Monitoring forms are inconsistently documented with the restraint monitoring forms also used to document cares and status of the resident as per the hourly monitoring check form. Documentation of the time the restraint went on and off is unclear in some files. | Document monitoring of the use of restraint as per timeframes documented in the care plan and in the restraint assessment and review form. | 30 |
| HDS(RMSP)S.2008 | Criterion 2.2.3.5 | A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | The restraint register does not clearly identify whether the resident is using a restraint or an enabler with three residents documented as having both. | Document a register denoting residents using restraint or an enabler. | 90 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a code of rights policy.  On interview all staff (two caregivers who work across rest home and hospital residents), three registered nurses (RN) and the nurse manager (registered nurse), are aware of resident rights and are able to describe how they incorporatd consumer rights within their service delivery.  Seven of seven residents (three rest home and four hospital) and six of six family members (two rest home and four hospital) interviewed spoke highly of the staff respect of all aspects of the Code of Rights.  Code of rights training is included in training provided to staff including privacy (October 2013), professional boundaries (October 2013), communication (July 2013). The service has been open since March 2013 and there has been a staggered approach to orientation. Staff have all received an orientation to the service that has included training around Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). |

##### 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.

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

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

Consumers are informed of their rights.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are posters of the code of rights on display throughout the facility and leaflets in the foyer of the facility.  On entry to the service residents receive an information pack that includes a information around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and a service agreement. Large format and Maori information is also available and posters in English and Maori displayed.  Two caregivers who support rest home and hospital residents, three registered nurses, the village manager and the nurse manager inerviewed state that they take time to explain the rights to residents and their family members. On entry to the service the nurse manager or registered nurse discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss.  Seven of seven residents (three rest home and four hospital) are able to state their understanding of the code of rights.  D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, rights information, advocacy and Health and Disability Commission information. |

##### 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a privacy and dignity policy.  Staff are observed respecting residents privacy and can describe how they manage maintaining privacy and respect of personal property.  All seven residents (three rest home and four hospital) and six of six family members (two rest home and four hospital) interviewed interviewed indicated staff were highly respectful and maintained residents privacy especially when discussing personal issues and that personal belongings are not used as communal property.  Privacy training last occurred in October 2013.  D4.1a The residents initial assessments and care plans detail their cultural needs, values, ethnicity and spiritual beliefs. Staff are familiar with the information in these documents and practice accordingly as described by the two caregivers, three registered nurses and the nurse manager interviewed.  There is a cultural awareness policy. All seven residents (three rest home and four hospital) interviewed state their needs were met.  All six resident files reviewed (three rest home and three hospital) have individual demographic information recorded about residents preferred name and staff were observed speaking respectfully to residents by their preferred name. All residents and family members interviewed can confirm this. There is a spiritually policy. There are various churches locally and residents are encouraged to attend these if possible and as per their choice. Multidenominational services are conducted in the facility at least once a week.  All residents and family members interviewed indicate that residents spiritual needs are being met when required. Resident preferences are identified during the admission and care planning processes occur with family involvement. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with residents all confirmed that choices are considered. On interview, two caregivers described how they encourage residents to engage in activities in the facility and to link with community activities including RSA and church groups. There is a preventing abuse and neglect policy and the topic is covered at orientation with this completed in the past year by all staff.  Staff interviewed are able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues.  Discussions with the village and nurse managers identified that there have been no episodes of abuse of neglect at the facility since it opened and there are no incidents of abuse documented in incident forms reviewed. D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. |

##### 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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A3.2: The service has established cultural policies to help meet the cultural needs of its residents. There is a Maori health plan that includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e) and a Maori health policy. The rights of the resident to practise their own beliefs is acknowledged in the Maori health policy and plan. The plan and policy have been developed by Summerset in consultation with Maori advisors. There are presently no residents who identify as Maori. The service has access to a comprehensive cultural assessment appropriate to Maori needs and details whānau input around the initial assessment and care plan development and reviews that can be used if needed.  Summerset Falls identifies cultural safety issues for Maori and can manage these on an individual basis as described by the three nurses and nurse manager interviewed.  There are two staff members including the village manager who are able to converse in te reo if needed.  D20.1i: The service is able to access Maori advisors and local iwi advocacy services as identified in the Maori health policy and plan.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. This is also incorporated in individual activity plans. Resident admission and on-going assessment is undertaken by the registered nurses with the inclusion of the family / whānau (where approved by the resident). The service identifies opportunities to involve family/whānau in all aspects of planning individual’s service delivery. Policies for Maori emphasise the critical importance of whānau. Discussions with the nurse manager, three registered nurses and two caregivers confirm that they are aware of the need to respond to cultural differences. On interview all staff are able to identify how to obtain support so that they could respond appropriately.  Cultural safety and Treaty of Waitangi training has been provided to staff as part of the orientation programme and in October 2013. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a cultural awareness policy which describes the cultural needs of residents. There is a Maori health plan and policy.  All seven residents interviewed (three rest home and four hospital) report that they are satisfied that their cultural and individual values were being met.  D3.1g: The service provides a culturally appropriate service by carrying out a cultural assessment on admission with family/whānau involvement when available. Family are involved in assessment and the care planning process.  D4.1c: Care plans reviewed (six including three rest home and three hospital) include the residents social, spiritual, cultural and recreational needs. Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan which the resident (if appropriate), and/or their family/whānau are asked to consult on. Agreement is reached by all parties involved in the consultation process and the care plan is implementation within the service delivery. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a sexual behaviour policy which states there will be zero tolerance against any discrimination occurring.  The abuse and neglect policy covers harassment and exploitation.  All seven residents interviewed (three rest home and four hospital) report that staff show respect and there is no evidence of discrimination or coercion. Elderly abuse prevention training occurs at orientation and on a two yearly basis and includes professionalism and standards of conduct with all staff having had training around abuse and neglect as part of orientation in 2013 (orientation checklists documented in six of six staff files reviewed). The nurse manager and registered nurses supervise staff to ensure professional practice is maintained in the service.  Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has policies to guide practice that align with the health and disability services standards.  There is a quality and risk framework and programme that is being implemented that includes performance monitoring.  The caregivers are expected to complete Career Force NZQA level two training as a minimum and an internal in-service training programme is implemented.  Across Summerset, quality data benchmarking groups are established for facilities with similar service provision. Summerset Falls is currently benchmarked with other Summerset facilities.  Both the nurse manager and the village manager attend external training sessions appropriate for their positions. The service has made improvements since the opening of the service in March 2013 and these include;  a) Promoting integrated services and activities between village and care centre. b) Staff employed to meet occupancy and acuity rates. c) Systems and processes started as of July 2013 using Summerset policies and procedures (refer 1.2.3).  d) Remodelling of the resident kitchen in the continuing care dining area to accommodate residents including those in wheelchairs who may wish to cook. e) Notice boards in resident rooms with updates around the service and photos of key workers for the individual resident.  f) There are communication books in each resident room that allows family and others to note any issues/communication they wish to have. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open disclosure policy which describes ways that information is provided to residents and families.  There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide on-going feedback.  Regular contact is maintained with family including if an incident or care/ health issues arises.  Family members interviewed state they are well informed and involved when needed in residents care.  D16.4b: All seven residents (three rest home and four hospital) and six of six family members (two rest home and four hospital) interviewed confirm the admission process and agreements documentation were discussed with them.  Residents and family state the service provides an environment that encourages open communication.  The admission agreement covers all the areas for the services contractual requirements. All six resident files reviewed include signed admission agreements on the date of admission.  Discussions with two caregivers identified their knowledge around open disclosure and reporting to registered nurses who in turn contacts family.  Fifteen of fifteen incident/accident forms reviewed identify that the next of kin is contacted or if family did not wish to be contacted. There have been two resident meetings in September and October 2013 where any issues or concerns to residents are able to be discussed.  Annual resident and relative surveys are also completed – last completed in September 2013. Residents and relatives in the 2013 survey are satisfied with the service.  Staff wear name badges and there is a notice board in the continuing care centre with photos of staff. Each resident has a notice board in their room with a photo of the key nurse and caregiver involved in their care. The service has policies and procedures available for access to DHB interpreter services and residents (and family/whānau), are provided with this information in resident information packs. There are currently no residents requiring the use of an interpreter. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Staff have had training around positive communication last in July 2013. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Informed consent policies include; informed consent and associated form and a refusal of treatment form, The informed consent form includes medical, lighten up (no lifting), transport, purchases and charges. Informed consent information is included in the information pack for new residents. The consent policy includes clear instructions for providing information to residents during the admission process. The nurse manager or registered nurses discussed informed consent processes with residents and their families during the admission process. Seven of seven relatives confirmed that informed consent had been discussed with them.  There is an advanced directive policy, a not for resuscitation policy and a not for resuscitation authorisation by competent resident form, a not for resuscitation authorisation for incompetent resident form and a resuscitation authorisation form. Discussions with two caregivers confirm that they are familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with the nurse manager and three registered nurses identifies that they are familiar with advanced directives and the fact that only the resident (deemed competent) can sign the advance directive. Completed resuscitation treatment plans and resuscitation advance directive forms are completed on six of six files.  The nurse manager and registered nurses are responsible for ensuring consent is gained on admission (or close to). D13.1 There are six admission agreements sighted and all have been signed on the day of admission D3.1.d Discussion with six of six family members (two rest home and four hospital) identifies that the service actively involves them in decisions that affect their relatives lives. |

##### 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.

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

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

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

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

##### Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an advocacy policy. Staff last received training on advocacy services as part of the orientation in 2013.  Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details.  The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information.  There is a residents meeting facilitated by an external advocate. The advocate takes meeting minutes (viewed) and communicates with the village manager regarding issues raised.  Advocate support is available if requested. Interview with two caregivers, seven of seven residents (three rest home and four hospital) and six of six family members (two rest home and four hospital) confirms that they are aware of advocacy and how to access an advocate. D4.1d; Discussion with six family identified that the service provides opportunities for the family/EPOA to be involved in decisions.  D4.1e: The resident file includes information on resident’s family/whānau and chosen social networks. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff state that residents are encouraged to build and maintain relationships. On interview all residents and family members confirmed this. D3.1h: Discussion with six of six family members (two rest home and four hospital) interviewed state that they are encouraged to be involved with the service and care D3.1.e: Discussion with staff, residents and family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church, and community groups. Examples given of residents attending activities in community include one who goes home to have lunch with family, one who attends Probus, one who attends stroke club and one who attends a craft group.  Visitors are encouraged to attend and were seen visiting the service on the days of the audit.  Six of six family members (two rest home and four hospital) interviewed confirm that they can visit at any time.  The village manager confirms that family can be accomodated when the resident declines. This is made available in the rooms or in other areas of the service if there is full occupancy. |

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

Consumers have access to visitors of their choice.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information around complaints is provided on admission. Interview with seven residents (three rest home and four hospital) and six of six family members (two rest home and four hospital) interviewed confirms an understanding of the complaints process.  All staff interviewed including two caregivers who support rest home and hospital resident), three registered nurses and the nurse manager are able to describe the process around reporting complaints There is a complaints register. The 2013 complains reviewed show that there is response to the complaint in a timely manner. Verbal and written complaints are documented as stated by the village manager.  Complainants are provided with information on how to access advocacy and Health And Disability Commissioner if resolution is not to their satisfaction and the village manager sends the leaflet as well in the response pack. Discussions with seven residents and six family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset Falls provides rest home and hospital level care for up to 41 residents - all are swing beds. On the day of the audit there are 28 residents - 15 rest home including two residents in a care apartment and 13 hospital including one resident in an apartment (just being reassessed again for rest home level care).  There is a retirement village attached as part of the complex with overall management of the site provided by a village manager.  The philosophy, vision and values is documented as part of the quality plan and included in the admission pack. The service is managed by an experienced manager who has previous management in an elderly care facility for six years in total and has extensive experience as a caregiver working for over 15 years in aged care facilities. The village manager has completed an orientation with Summerset which includes employment and administration, specific policies to read and sign, meeting schedule, tour of site, customer service, communicating with staff, contracts and auditing, health and safety, HR, emergencies, finance, primary care, intranet use, IT protocols, key staff members, resident care and services, sales and marketing, visiting another Summerset site performance management, property and maintenance, quality and the Summerset way (philosophy).  A nurse manager is employed to oversee the clinical running of the rest home and hospital. The nurse manager is supported by an organisation clinical and quality manager and registered nurses. The nurse manager has been in the role for six months and has previous clinical management experience on a home care environment.  Summerset has comprehensive quality and risk management systems implemented across its facilities. There is an overall Summerset 2013 strategic and organisational risk management plan.  There is a 2013 business plan that is reviewed through the quality meeting.  Summerset provides a comprehensive orientation and training/support programme for their managers.  Village managers have monthly teleconference meetings with head office operations staff.  The nurse manager is mentored and supported by the village manager and the clinical education manager from head office. ARC, D17.3di (rest home), D17.4b (hospital): The village manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital including health and safety level one training, privacy, and hospice palliative care training in 2013. |

##### 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During the temporary absence of the manager, the nurse manager undertakes the role of manager.  The nurse manager has a background 19 years in aged care including nursing in palliative care, district nursing, home care.  D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D5.4 The service has up to date policies/ procedures to support service delivery. New or revised policies are available for care staff to read and sign that they have read and understand the changes (policy release folder). Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.  There is a document control programme with reviews dated and documented.  There is a quality plan that is being adjusted in 2014 to include quality objectives relative to Summerset Falls.  The quality programme is reviewed annually and is being implemented. Information is reported through the monthly meeting (minutes sighted and documented since July 2013) and staff meetings with data documented.  The monthly quality meeting discusses key components of the quality programme and standing agenda items of the programme include internal audits, infection, restraint, incidents, complaints and health and safety.  Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet.  Complaints are documented in the complaints register. An infection rate monthly summary is completed. The clinical and quality manager analyses all infection control statistics and incidents and accidents monthly with a graph produced that enables the service to benchmark data against similar services. The quality meeting minutes is expected to document any benchmarking activity and meeting minutes reviewed for 2013 state that this has not been accessed from the head office.  There is a weekly management meeting that includes the village, nurse, property, office managers. Minutes are documented appropriately. There is a staff meeting monthly with data documented. Two of the meetings since July 2013 have minutes completed.  The service is starting to introduce three monthly restraint, infection control and health safety meetings in 2014. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is reviewed annually.  Summerset has a data tool "Sway- The Summerset Way" that was launched in 2012 by the organisation. Sway is integrated and accommodates the data entered.  The internal audit schedule is implemented since July 2013. Corrective actions are documented.  D19.3: There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as use of sensor mats, falls risk assessments conducted, physiotherapy input, exercise programme and increased supervision of residents with frequent falls.  Resident meetings occur two monthly (held in September and October 2013).  Annual surveys are conducted of residents and relatives – last completed in October 2013. There is an annual food satisfaction survey completed last in September 2013.  All residents and relatives interviewed stated they are regularly asked for feedback regarding the service.  Improvements are required to documentation of resolution of corrective actions, documentation of staff meeting minutes and completion of benchmarking activities in line with policy. |

##### 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.

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are monthly quality and staff meetings and weekly management meetings.  There is a new template to document the staff meeting minutes on and the village manager states that these will be used for the next staff meeting as planned by head office.  The service is starting to introduce three monthly restraint, infection control and health safety meetings in 2014. Benchmarking data is documented by head office and is able to be provided on request. |
| **Finding:** |
| (i)Staff meetings are sparsely minuted and do not include all aspects of the quality programme. (ii) The quality meeting minutes consistently state that benchmarking data should be provided however this has not been tabled in any meetings. |
| **Corrective Action:** |
| (i)Document staff meeting minutes and include all aspects of the quality programme. (ii) Use benchmarking data to improve quality. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Corrective actions are documented. |
| **Finding:** |
| There is limited evidence of resolution documented against corrective actions. |
| **Corrective Action:** |
| Document evidence of resolution of corrective actions. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information.  The reporting system is integrated into the quality risk management system.  Once incidents and accidents are reported the immediate actions taken are documented in incident forms. The incidents forms are then reviewed and investigated by the nurse manager who monitor issues. If risks are identified these may also be processed as hazards.  Incidents are trended monthly and reported through the monthly quality meetings. The clinical and quality manager analyses all infection control statistics and incidents and accidents are graphed monthly with discussion at the quality meeting. Discussion with the village manager indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.  Fourteen of15 incident forms included appropriate clinical follow up by a registered nurse (refer 1.3.6.1). |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are comprehensive human resources policies as part of the policy manual, this includes job descriptions. There are employment guidelines and templates which include application form, interview questionnaire, reference check forms and standard letter for employment. Recruitment and employment is completed by the nurse manager for the registered nurse roles with support from the village manager and by the village manager for other roles.  The service has recruited staff to meet occupancy and acuity requirements and this is per the staffing model documented in the policy.  Six of six files reviewed indicate that all have a documented contract signed by the employee and employer, orientation, application, police check, training records (refer 1.3.12), a current annual practicing certificate if required and referee checks.  There is a training policy for staff that includes the provision of compulsory subjects and a training programme will be implemented. The 2013 training programme sighted includes key aspects of the health and disability standards. Orientation of caregivers includes completion of stage one Careerforce and all who have not got this already are expected to start this as soon as they have completed orientation with the intention that they complete this within six months. Staff interviewed are able to describe their roles as per their job description.  There are current annual practicing certificates for all health professionals associated with the service e.g. doctors. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff including three registered nurses, two caregivers and the nurse and village manager’s report that staffing levels and the skill mix was appropriate and safe. All six family members (two rest home and four hospital) advise that they felt there was sufficient staffing.  The service has a staffing levels policy implemented, which determines that there are registered nurses on duty at all times, and that at least one staff member on duty will hold a current first aid qualification – roster reviewed indicates that this occurs.  New staff are rostered on duty with an experienced staff member during the orientation phase of their employment. Advised that the roster is able to be changed in response to resident acuity and the spreadsheet to accommodate this is documented.  Medirest provides staff for food services as part of their contract. The service employs 48 staff including the following: cleaners (seven days a week), recreational staff (30 hours per week with a move to provide activities seven days a week), administration person (40 hours per week), property manager (40 hours per week), 15 caregivers, two cooks, eight registered nurses, one village manager and one nurse manager (40 hours per week).  There is a registered nurse rostered on 24 hours per day.  Morning shift includes four caregivers including one short shift; afternoon shift - four care givers including one short shift; night duty - two caregivers. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Prior to entry to the service residents are assessed by a NASC agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. This includes a coordinated process including GP, resident, family/whānau (where appropriate).  All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Residents files are integrated and include allied health professional, specialist and GP input and reviews. The files also include short and long term care plans, and any medical reports such as radiology and pathology. Information in files is appropriate to the rest home and hospital setting. The service keeps a resident register.  Summerset Falls has a policy and process that describes the control of documents and records that outlines expectations for record keeping and retention times for specific documents and records. Residents personal records are appropriately managed to meet the requirements of relevant legislation and standards.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured room. Old files are individually archived and locked in a secure area for 10 years Resident records are up to date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel. Care plans and progress notes are legible. |

##### 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.

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

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

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

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

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission to services there is an assessment of residents and this was evidenced in all six resident files reviewed. Seven of seven residents (three from the rest home and four from the hospital) and six of six families (two from the rest home and four from the hospital) all stated that they kept informed on admission.  There is a well-developed information pack which included advocacy, health and disability information, fees - where applicable, recreation services, menus and services available. There is a care facility - resident admission and orientation policy and procedure The service has a comprehensive admission policy including that information gathered at admission is retained in resident’s records. Seven of seven residents (three from the rest home and four from the hospital) state they were given an information pack when viewing the facility and were able to discuss the admission process with the nurse manager and registered nurses. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility. D14.1 Exclusions from the service are included in the admission agreement. D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The reason for declining service entry to residents is recorded and advised should this occur it is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.2, 3, 4: The nurse manager or registered nurses undertake the assessments on admission. The initial support plan is completed within 24 hrs of admission in six of six files sampled (three from the rest home and three from the hospital). There is documented evidence that the care plans were reviewed by the nurse manager or registered nurses and amended when current health changes. Three of the six care plans sampled have been evaluated within six months. The other three residents have not yet been at the service for six months. Within three weeks the long term care plan is completed by the clinical nurse leader or registered nurses as sighted in the seven files sampled.  Activity assessments and activities care plans were completed by the diversional therapist in all files reviewed.   D17.1 (b) Copies of the registered nurses, GPs and other allied health providers practising certificates are copied and kept on file by the management team.   D16.5e: All six resident files reviewed identified that the general practitioner had seen the resident within two working days. It was noted in the six resident files reviewed that the general practitioner has assessed the resident as stable and is to be seen three monthly that these reviews have occurred alongside as needed reviews. Two caregivers (who worked across all shifts) and the nurse manager and the registered nurse interviewed describe a verbal and written handover at the beginning of each shift where any issues or changes in resident status are discussed.  Progress notes are written every shift by caregivers, or more often if there are any changes. RNs also write concerns in the medical notes.  All six resident files identify integration of allied health personnel and a team approach is evident.  Tracer Methodology rest home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology hospital: 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The initial support plan is developed with information from the initial assessment. The registered nurse assessment tool includes; communication, mental status, mood, bathing and dressing, nutrition, sleep patterns, skin integrity, eating, elimination, UTI's, respiratory and cardiovascular and bowel management. This assessment tool is updated six monthly for each resident as sighted in three of three files sampled (one from the rest home and two from the hospital) where the resident has been at the service longer than six months. The other three files sampled were for residents who have not been at the service for six months. Risk assessment tools and monitoring forms are available and implemented and are used to effectively assess level of risk and required support for residents including (but not limited to); resident mobility scale, safe handling, Braden, falls, continence and diet. The service uses the MUST nutrition tool and these are completed monthly for each resident. One of six files sampled is for a resident who present behaviours that challenge. This file contains a behaviour assessment and related plan.  Additional assessments are noted such as the Bristol stool chart and cultural assessments. Continuing needs/risk assessments are carried out by registered nurses.  Needs outcomes and goals of consumers are identified and these link to care plans including falls assessments, continence care and diet (link 1.3.5.2). Six of six files sampled (three from the rest home and three from the hospital) contain all relevant assessments and these are current. Seven of seven residents (three from the rest home and four from the hospital) and six of six families (two from the rest home and four from the hospital) interviewed report having been involved in the assessment process. |

##### 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.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Six care plans were reviewed for this audit, three hospital and three rest home (including one resident in a care apartment). Assessment tools relevant to a specific area of the support plan are completed.  Residents' files include; daily progress notes, recordings - bowel and fluid charts, family contact record, short term care plans/wounds, long term care plans, risk assessments/nutrition, restraint/enabler documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes. Service delivery plans (lifestyle care plans) demonstrate service integration and demonstrate input from allied health including physiotherapist, GPs and podiatrist in six of six files sampled.  Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) are maintained by registered nurses. Care plans reflected current care in two of the six files sampled. This is an area requiring improvement. D16.3k: Short term care plans are in use for changes in health status. D16.3f Six of six files sampled (three hospital and three rest home (including one resident in a care apartment)) reviewed identified that family were involved. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Six care plans were reviewed for this audit, three hospital and three rest home (including one resident in a care apartment). Assessment tools relevant to a specific area of the support plan are completed.  Residents' files include; daily progress notes, recordings - bowel and fluid charts, family contact record, short term care plans/wounds, long term care plans, risk assessments/nutrition, restraint/enabler documentation, care plan evaluations (MDT review), GP initial assessment and visits, lab results, allied health reports/progress notes, activities, consents and advance directives, letters, referrals and archived notes. Service delivery plans (lifestyle care plans) demonstrate service integration and demonstrate input from allied health including physiotherapist, GPs and podiatrist in six of six files sampled.  Notes are maintained by the general practitioner and allied health professionals and significant events, communication with families and notes (as required) are maintained by registered nurses. Care plans reflected current care in two of the six files sampled. |
| **Finding:** |
| Four of six files sampled do not include interventions for all identified areas of need. Examples include weight loss, continence and risks associated with the use of a bed rail. |
| **Corrective Action:** |
| Ensure that care plans include interventions for all identified areas of need. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Service delivery plans demonstrate service integration.

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Summerset Falls provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. (see CAR 1.3.5.2 in regards to documentation). The care being provided is consistent with the needs of residents; this is evidenced by discussions with the six caregivers, seven of seven families (four from the hospital and three from the rest home), the nurse manager, three registered nurses and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.  Two of six care plans reviewed are well written, and appropriate language for caregivers (see CAR 1.3.5.2).  Six residents files were sampled (three hospital and three rest home (including one resident in a care apartment)). All six residents had ADLs and nutrition well documented. The progress notes all document that the RN has reviewed progress notes weekly and followed up any outstanding problems identified.   Turning charts and food and fluid charts were sighted for two residents. All turning charts and one of two food and fluid charts were completed accurately and show appropriate care being provided. This is an area requiring improvement. One resident has been identified as requiring fortnightly weighs following weight loss and these have not occurred. One resident who has multiple falls has had two falls with head injuries. One of these falls required hospitalisation. Neurological observations were not completed for either of these falls. These are also areas requiring improvement.  D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. There are eight residents with 14 wounds. None of these wounds are pressure areas and most (11) are skin tears. All of these have an associated short term care plan which includes a wound management plan. Eleven of the 14 wounds have not been reviewed in the stated timeframe. For most wounds the gap is three to five days but for one wound the gap is 11 days and for another nine days. This is an area requiring improvement.  There is also an improvement required around the signing and dating of documents. The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. The GP was not available to be interviewed. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Summerset the Falls provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. Overall the lifestyle care plans are completed comprehensively (see CAR 1.3.5.2). The care being provided is consistent with the needs of residents, this is evidenced by discussions with the six caregivers, seven of seven families (four from the hospital and three from the rest home), the nurse manager, three registered nurses and the village manager. There is a short-term care plan that is used for acute or short-term changes in health status.  Two of six care plans reviewed are well written, comprehensive and appropriate language for care givers (see CAR 1.3.5.2).  Six residents files were sampled (three hospital and three rest home (including one resident in a care apartment)). All six residents had ADLs and nutrition well documented. The progress notes all document that the RN has reviewed progress notes weekly and followed up any outstanding problems identified.   Turning charts and food and fluid charts were sighted for two residents. All turning charts and one food and fluid chart were completed accurately and show appropriate care being provided.   D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-services and wound management in-service have been provided. There are eight residents with 14 wounds. None of these wounds are pressure areas and most (11) are skin tears. All of these have an associated short term care plan which includes a wound management plan. |
| **Finding:** |
| (i)One resident has a food and fluid chart that has not been completed to show an accurate portrayal of the resident’s intake. (ii) One resident has been identified as requiring fortnightly weighs following weight loss and these have not occurred. (iii) One resident who has multiple falls has had two falls with head injuries. One of these falls required hospitalisation. Neurological observations were not completed for either of these falls. (iv) Eleven of the 14 wounds have not been reviewed in the stated timeframe. For most wounds the gap is three to five days but for one wound the gap is 11 days and for another nine days. |
| **Corrective Action:** |
| (i)Ensure food and fluid charts are accurately completed. (ii) Ensure weights are completed as required. (iii) Ensure neurological observations are completed for falls with a potential head injury. (iv) Ensure wounds are reviewed within stated timeframes. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The recreational therapist works Tuesday to Saturday. There was no recreation person employed from the time the service opened in March 2013 until August 2013. The current recreation therapist has resigned and is working out the last few days of her notice. The nurse manager reports she is in the final stage of recruiting into the position. The activities programme is developed by the recreational therapist and each resident receives a copy of the monthly plan. The plan is easy to read and colourful, it can be printed in large type to assist those residents with who are visually impaired.  Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in crafts, and an exercise programme. There is also reminiscing, music, art, entertainment, themed activities and a variety of activities to maintain strength and interests. There are frequent (at least twice weekly) outings including to annual community events such as the Orewa hot rod show, shopping trips to the Warehouse, nearby Mitre 10 or other garden stores (which residents enjoy and request) and a monthly lunch outing. The two rest home level residents living in serviced apartments are included in the activities programme and invited often although both currently decline to attend. There is a separate programme run by another person for other village residents.  D16.5d: Monthly progress notes are written in six resident files reviewed. A diversional therapy assessment documents a social history and previous interests. All assessments and pans for recreation for residents at the service before August 2013 were completed in August and September 2013 following the appointment of the recreation therapist. None are yet due for six monthly evaluation. Six of six files sampled (three from the rest home and three from the hospital) have a documented activities plan. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is evidence of resident and family (where appropriate) involvement in the review of support plans.  D16.4a Three of the six care plans sampled have been evaluated within six months. The other three residents have not yet been at the service for six months and have not required a care plan evaluation. Two of six files sampled (one from the rest home and one from the hospital) indicate that the care plan has been updated when needs change (see CAR 1.3.5.2). There are short term care plans to focus on acute and short-term issues. Changes to the long term lifestyle care plan are made as required.   ARC D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with the nurse manager identified that the service has access to (but not limited to); speech language therapist, physiotherapist, diabetic nurse, wound care nurse, needs assessment, and geriatrician and this was evidenced in six files reviewed. Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made. |

##### 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.

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011. The facility uses monthly supplied blister medication packs. Medications are checked on arrival at the facility.  All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily.  Twelve resident medication charts were reviewed and all are identified with photographs and were current. There is no evidence of transcribing and all 14 medication charts sighted have been signed. On three of 12 medication charts there are PRN medications charted that do not document an indication for use. A further three of 12 medication charts sampled have regular non packaged medications that are not always signed as administered as prescribed. These are areas requiring improvement.  Three monthly medication review for the 12 residents was documented on the prescription chart.  There is a list of staff with specimen signatures that have been assessed as being competent to administer medications.  Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. Weekly stocktakes have not always occurred and this is a further area requiring improvement. All registered nurses that administer medication have received medication management training in November 2013. The clinical manager and registered nurse interviewed were conversant with the service medicine management policies procedures. Four of the eight registered nurses do not have medication competency assessments and this is an area requiring improvement. There is a self-medicating resident’s policy available to guide staff practice if required. There are currently two residents self-administering medicines and the GP has documented that each of these two residents is competent to self administer their medicines. Medication audits occur annually. The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Medication and any changes are discussed with the resident or family/whanau where appropriate and documented in the progress notes. This was verified in resident and family interviews. All medication in the fridges, drug trolleys and cupboard were sighted.  D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011. The facility uses monthly supplied blister medication packs. Medications are checked on arrival at the facility.  All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily.  Twelve resident medication charts were reviewed and all are identified with photographs and were current. There is no evidence of transcribing and all 14 medication charts sighted have been signed. Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. |
| **Finding:** |
| (i) On three of 12 medication charts there are PRN medications charted that do not document an indication for use. (ii) A further three of 12 medication charts sampled have regular non packaged medications that are not always signed as administered as prescribed. (iii) Weekly stocktakes of controlled drugs have not always occurred. |
| **Corrective Action:** |
| (i)Ensure PRN medications document an indication for use. (ii) Ensure medication charts medications are administered as prescribed. (iii) Ensure weekly controlled drug stocktakes occur. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| All registered nurses that administer medication have received medication management training in November 2013. The clinical manager and registered nurse interviewed were conversant with the service medicine management policies procedures. |
| **Finding:** |
| Four of the eight registered nurses do not have medication competency assessments |
| **Corrective Action:** |
| Ensure all staff who administer medications have a medication competency assessment. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a large kitchen and all food is cooked on site by contractors. D19.2: All staff working in the kitchen have food handling certificates and receive ongoing monthly training from Compass. On admission the registered nurse completes a dietary profile and communicates individual resident’s needs to the kitchen staff.  This information is updated as required. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process.  There is a daily cleaning schedule in place. There is a comprehensive kitchen manual in place. The menu has been reviewed by a dietitian, last in September 2013. Audit of the main kitchen noted that fridge and freezer temperatures are monitored daily and are within acceptable limits. This audit noted that all food in the fridge and pantry is dated and labelled. Meat is noted to be stored correctly and the kitchen is very clean. Residents with special dietary needs have these needs assessed as part of the care planning process. The six care plans reviewed all had eating and drinking assessed as part of the MUST nutrition assessment tool completed monthly, and some care plans reflected any special needs (link 1.3.5.2). Seven of seven residents (three from the rest home and four from the hospital) and six of six families (two from the rest home and four from the hospital) report a high level of satisfaction with meals. There is a kitchen manual. |

##### 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.

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures for waste disposal.  The care centre has secure storage areas for chemicals including a locked housekeeper’s cupboard with material safety data sheets.  The apartments have 'home-like' facilities if the resident choses to complete their own housekeeping.  The service has an accident/incident system for investigating, recording and reporting incidents. There have been no incidents noted since the service opened around waste or hazardous substances management.  There is an audit completed around waste management and chemical substances in October 2013.  There is blood and body fluid spill management policy.  Waste and hazardous substance management is included on the training policy as part of infection control training with infection control training last provided in January 2014. All staff have completed chemical training January 2014. Gloves, aprons, and goggles are available for staff and were sighted being used on the day of the audit.  Infection control policies state specific tasks and duties for which protective equipment is to be worn. There are sharps boxes in the treatment room and staff state that these are returned to pharmacy when full. |

##### 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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Summerset Falls is a purpose built care facility for rest home and hospital level care with eight apartments in the same building.  There is a code of compliance issued on the 27 May 2013 and the property manager and clinical and quality manager state that this is to be replaced in February 2014 with a building warrant of fitness as per the compliance schedule statement expiry 1 February 2014.  Summerset Falls is on three levels with the eight apartments on the ground floor. There is a lower ground floor with two licensed to occupy apartments, a ground floor that also includes the recreation centre, administration, library, the main kitchen laundry, gym and a café and a first floor with 41 beds care centre.  There is access for the cleaners to the ground and first floors. There are three scooter parks on the ground level and one on the lower ground level.  The care centre includes a communal lounge, communal dining area, and kitchenette. The staff room is located on the same floor as the care centre. There is one lift and two internal and two external fire egress stair wells. All building and plant have been built to comply with legislation.  The organisation has purchased all new equipment. Residents bring their own possessions into the home.  There are handrails in en-suites and communal areas as necessary. All rooms and communal areas allow for safe use of mobility equipment. Resident rooms are of appropriate size to ensure safety is not compromised.  There is a transportation of resident’s policy which provides guidelines for managing resident and staff safety while being transported and there is a manual handling policy.  There is safe access to outside areas that includes level access to the ground floor and there is an outside deck area off the first floor care centre. Garden areas are landscaped with seating and tables available. Umbrellas are available for shade. There is a fully fenced spa pool with a safety gate and a bowling green.  There is a preventative maintenance plan that is electronically documented with evidence of checks completed as per the schedule. This includes tag and testing of equipment (completed last in September 2013).  Summerset Falls is beside a river that is unfenced. This is included on the hazard register. Currently there is one resident who has wandered-off twice and been returned to the facility by the community. The resident was admitted from a PG unit to rest home level care following reassessment. The service has had the resident reassessed by a psychiatrist on the second day of the audit following this being raised as a potential issue and the needs assessment service has accepted an urgent referral for reassessment.  An improvement is required to resident safety. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Summerset Falls is beside a river that is unfenced. The service has this included on the hazard register. Currently there is one resident who has wandered twice and been returned to the facility by the community. The resident was admitted from a PG unit to rest home level care following reassessment. The service has had the resident reassessed by a psychiatrist on the second day of the audit following this being raised as a potential issue and the needs assessment service has accepted an urgent referral for reassessment. The service is currently checking the resident hourly (hourly checks sighted as being completed). All staff interviewed are aware of the resident’s ability to wander and state that they check the resident more frequently than hourly. |
| **Finding:** |
| The river is unfenced and poses a risk to confused wandering residents. |
| **Corrective Action:** |
| Ensure that all residents continue to be safe at all times. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Thirty-seven rooms in the care centre have ensuites (toilet and showers). Four other rooms have a communal shower and toilet that is readily accessible to all four residents. There are communal toilets close to lounges, dining area and recreation rooms and the communal toilet close to the recreation room is also the designated visitor’s toilet.  Staff toilets are located away from clinical service areas in the staff room.  Each apartment is fully serviced with a shower and toilet.  There are tempering valves in place and hot water monitoring will be commenced.  Fixtures, fittings and floor and wall surfaces in bathrooms and toilets have signage in place and the service has developed a series of flip charts for each resident door used by the resident to inform others of whether they wish to be disturbed etc.  There are paper towels and flowing soap dispensers in use in all areas.  Since the last audit, the service has put doors on the communal men’s and women's toilets close to reception and there is now a door between the toilet and the staff room and the kitchenette/staff area. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are 41 bedrooms in the care centre and eight serviced apartments. All rooms in the care centre are large enough to provide hospital level care, allowing the use of mobility equipment in the rooms and corridors.  Rooms can accommodate a hoist and any other equipment that may be used.  Resident rooms have one and half width doors. Doorways into residents' rooms and communal areas are wide enough for wheelchairs.  There are wide hallways throughout the facility. Lifts in the facility can accommodate a bed.  Mobility scooters are able to be parked in designated bays. Two of two caregivers report that rooms have sufficient room to allow cares to take place.  Residents are observed manoeuvring wheelchairs/wheel walkers in rooms safely. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Adequate access is provided to lounge and dining areas. There is a large lounge and a large open dining room with a kitchenette on the continuing care floor and residents are encouraged to use this. The kitchenette is large enough to accommodate hospital level residents and associated equipment with benches that are at the height for residents using wheelchairs.  There is a family/whanau room on the continuing care floor that is used as a withdrawal room and this also includes a kitchenette.  There is a large lounge on the ground floor with a library, café, recreation area including a pool table and a gym on the lower ground level. The serviced apartments also have their own lounge and dining area.  There is adequate space for manoeuvring with mobility aids in communal areas.  Activities occur predominantly in the dining/lounge area as observed on the day of the audit.  D15.3d Seating and space is arranged to allow both individual and group activities to occur.  Residents are able to move freely and furniture is well arranged to facilitate this.  Residents are seen to be moving freely both with and without assistance throughout the audit and seven residents interviewed (four hospital, three rest home) report they can move around the facility and staff assist them if required. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset Falls has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. All laundry is completed onsite daily and there are dedicated laundry and cleaning staff.  Laundry and cleaning audits are completed as per the quality programme with the laundry services audit completed in October 2013. The laundry and cleaning room are designated areas, clearly labelled and locked when not in use.  All chemicals are labelled with manufacturer’s labels and stored in a locked room with an audit completed around waste management and chemical substances in October 2013.  There is a sluice room for the disposal of soiled water or waste in the continuing care unit which is kept locked when unattended.  The laundry and cleaning areas have hand-washing facilities.  All staff have completed chemical training January 2014 and the housekeeper is a member of infection control, H&S and quality committee. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the rooms. There is a small laundry available for the eight serviced apartments for those who wish to be independent. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff have first aid training with a staff member with a first aid certificate on duty at all times.  Residents requiring further levels of supervision have these identified in their individual care plans as confirmed by the nurse manager.  Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. A fire evacuation was last held in August and October 2013.  D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The evacuation scheme is documented 19 June 2013.  The facility is well prepared for civil emergencies and has centralised emergency supply store. A store room has been equipped with all supplies needed in the event of an emergency including personal protective equipment. Alternative energy source includes lighting battery backup and gas bottles.  A store of emergency water is available (27 five litre bottles and a 10,000 litre water tank). There is gas bottles/BBQ for alternative heating and cooking and emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available.  Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency.  The call bell system is available in all areas and indicator panels in each area. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. Seven residents interviewed (four hospital, three rest home) state their call bells are answered in a timely manner.  There is sufficient food on site to last for at least three days and there is emergency lighting (battery operated) that will last for a minimum of six hours. The property manager states that the service has access to hireage of a generator if required.  Visitors sign in/out book at reception and the facility is secured at night. The front door is locked by staff at dusk and facility gate automatically closes at 10pm with lights on pathways and roads.  Staff at times attend to village residents when there is a call. Staff describe ringing firstly when the alarm goes to check that it has not been accidently triggered and if there is no answer, then they visit the resident. The staff member visiting carries a pager at all times and uses the village villa phone to ring.  There is safety fencing around the spa pool. |

##### 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.

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| General living areas and resident rooms are appropriately heated and ventilated. There is an air conditioning including heating system throughout the facility with heat pumps and a gas fireplace in the ground floor lounge.  Seven residents (four hospital, three rest home) and six relatives (four hospital, two rest home) interviewed state the temperature is comfortable. All rooms have external windows with plenty of natural sunlight apart from the family/whanau room which is an internal room.  There is a designated external smoking area. |

##### 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.

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

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

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

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

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

## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of Health and Disability Sector Standards 2008. The service currently has seven residents assessed as requiring the use of restraint and/or enablers.  The care plans include reference to the use of restraint.  On-going consultation with the resident and family/whanau is also identified. Falls risk assessments are completed on admission and six monthly. Staff also complete a falls assessment after a resident has two falls in any given month.  Challenging behaviour assessments are completed as required.  Policy states that enablers should be voluntary and the least restrictive option possible and the two caregivers, restraint coordinator (registered nurse) and the clinical nurse leader are familiar with this. Staff received training around restraint minimisation in October 2013.  The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers and the policy has been reviewed last in October 2013. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Responsibilities and accountabilities for restraint are outlined in the restraint policy that includes responsibilities for key staff.  The restraint co-ordinator (registered nurse) is able to describe the role and responsibilities and there is a job description of the restraint coordinator. Approval for each form of restraint is reviewed at a frequency as determined by the organisational restraint minimisation policy and with reference to resident safety. Six files reviewed (three rest home and three hospital) evidenced consent forms documented and two reviewed specifically around the use of restraint have consent forms signed by the resident or the enduring power of attorney/family consenting to the use of the restraint or enabler (refer 2.1.1). The use of restraint and enablers is discussed at the monthly quality meeting (meeting minutes sighted) with this meeting currently used to confirm approval of restraint The village manager states that there will be a three monthly restraint meeting/approval group meeting that will start in 2014. |

##### 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.

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The Summerset restraint minimisation policy outlines the organisation approach to managing restraint. This includes the use of a restraint assessment guide by the restraint coordinator and general practitioner, risk assessment, the need to attempt to modify behaviour prior to the use of restraint, resident advance directives, previous tolerance of restraint application, resident medical and social history, cultural considerations, alternatives to restraint use and the goals of the restraint intervention.  There is a brief assessment completed in the two files of residents using both restraint and enablers.  Family/whanau input and consent is required prior to the application of any forms of restraint at Summerset Falls – sighted on the assessment forms reviewed. Two of two files document some risks on the assessment form associated with the use of restraint however these do not relate specifically to each restraint when more than one is used.  The care plans identify the underlying causes of the relevant behaviour.  An improvement is required to the assessment of restraint. |

##### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two of two files document some risks on the assessment form associated with the use of restraint.  The care plans identify the underlying causes of the relevant behaviour. |
| **Finding:** |
| There is no documentation of consideration of alternatives to the use of restraint as part of the assessment process, assessment of risk related to each restraint, if the resident has used restraint in the past, relevant history, desired outcome and criteria for ending restraint and possible alternative interventions and strategies in the two files reviewed where the residents have both restraint and enablers used. |
| **Corrective Action:** |
| Document consideration of alternatives to the use of restraint as part of the assessment process, assessment of risk related to each restraint, if the resident has used restraint in the past, relevant history, desired outcome and criteria for ending restraint and possible alternative interventions and strategies. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The restraint policy states that the need for restraint use is monitored and reviewed as part of the general practitioner reviews three monthly and as part of the approvals group meeting three monthly when these start (refer 2.2.1).  Two files reviewed indicates that frequency of monitoring is documented on the review of restraint form and in the care plan.  Monitoring forms are inconsistently documented with the restraint monitoring forms also used to document cares and status of the resident as per the hourly monitoring check form. Documentation of the time the restraint went on and off is unclear in some files.  The service reviews individual use of restraint as part of the monthly quality meetings.  The restraint coordinator (registered nurse) and the nurse manager state that restraint is only used at Summerset Falls as a last resort after all other alternative techniques to modify behaviour or manage resident safety have been exhausted. This is outlined as policy requirements in the restraint minimisation policy.  The restraint minimisation policy requires that a restraint register is maintained with all residents’ names and restraint details included.  The restraint register is maintained and updated by the restraint coordinator as required (refer 2.1.1).  Improvements are required to the documentation of monitoring of the restraints and to the restraint register. |

##### 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.

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

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

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Monitoring forms are at times documented with the time the restraint went on and the time off.  Hourly monitoring forms are used to document checks on the resident which may include restraint. |
| **Finding:** |
| Monitoring forms are inconsistently documented with the restraint monitoring forms also used to document cares and status of the resident as per the hourly monitoring check form. Documentation of the time the restraint went on and off is unclear in some files. |
| **Corrective Action:** |
| Document monitoring of the use of restraint as per timeframes documented in the care plan and in the restraint assessment and review form. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a restraint and enabler register that is maintained by the restraint coordinator. |
| **Finding:** |
| The restraint register does not clearly identify whether the resident is using a restraint or an enabler with three residents documented as having both. |
| **Corrective Action:** |
| Document a register denoting residents using restraint or an enabler. |
| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The use of restraining devices is evaluated by the restraint coordinator (registered nurse) and registered nurses as part of the care planning review process in conjunction with the resident, their family/whanau and general practitioner.  On review of two files where the use of restraint is identified, there is evidence that plans are reviewed six monthly with a general practitioner review three monthly for all residents. This includes review of restraint.  There is an assessment and review of restraint also completed three monthly and this is documented in the two files reviewed (link 2.2.2.1 and 2.2.3.4).  Restraint use is discussed at the monthly quality meetings |

##### 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.

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

##### 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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset Falls reviews the use of restraint as part of its internal audit processes. The results of the restraint audit are discussed at the monthly quality meetings and any corrective actions identified are actioned through this forum. The restraint approvals group is to be set up in 2014 and until this is started, the quality meeting continues to be used to review approval. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control nurse is a registered nurse who has been in the role for three months. Prior to this, another registered nurse in the service was designated as the infection control coordinator and has provided a thorough handover to the new infection control coordinator as described by the infection control coordinator.  The infection control coordinator is supported by the nurse manager, clinical and quality manager at head office and registered nurses including the previous infection control coordinator.  The infection control coordinator can access external specialist advice from doctors, laboratories, other Summerset infection control nurses and the District Health Board infection control specialists/gerontologists when required.  The infection control programme is appropriate for the size and complexity of the service.  The programme is approved and reviewed annually by the infection control coordinator through the quality monthly meeting noting that a three monthly infection control meeting is due to start in 2014.  Infection control is a standing agenda item at the monthly quality meeting.  There is a job description for the infection control coordinator including the role and responsibilities.  There are policies and an infection control manual to guide staff to prevent the spread of infection.  Summerset Falls was opened in March 2013 and the infection control coordinator states that an annual review will be completed in March 2014. |

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

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

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control coordinator (registered nurse) provides an IC report to the monthly quality meetings (minutes reviewed).  The infection control coordinator can access external DHB, infection control nurse specialist, Bug Control, laboratories, and general practitioner specialist advice when required.  The infection control coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Summerset Falls has infection control policies and an infection control manual which reflect current practise.  D 19.2a: Infection control policies include hand hygiene, standard precautions, transmission-based precautions, outbreak management, antimicrobial usage, prevention and management of infections. The infection control policy was reviewed last in January 2013. |

##### 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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous infection control coordinator completed infection control training through Bug Control in September and November 2013 (certificates sighted). She is continuing to provide support to the current infection control coordinator.  Staff complete annual infection control education - last provided in August 2013 and hand washing in November 2013.  The training folder records the staff education session content and attendance records.  External resources, including DHB, laboratory, other Summerset IC nurses and general practitioners ensure the content of the education sessions are current and reflect best practice.  Resident education occurs as part of care delivery.  There is evidence of resident and visitor education when any issues arise with an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Infection monitoring is the responsibility of the infection control coordinator with a sound understanding of infection surveillance. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at Summerset Falls are appropriate to the acuity, risk and needs of the residents.  The infection control coordinator enters infections on to the infection register and infection information is entered into the Summerset database which generates a monthly analysis of the data. The analysis is reported to the monthly quality meetings that include a cross section of staff (minutes viewed). Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective as stated by the nurse manager. general practitioner's are notified if there is any resistance to antimicrobial agents. There is evidence of general practitioner involvement and laboratory reporting. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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