# Cressida Otago Limited

## Current Status: 17 February 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

Woodhaugh is part of the Cressida Healthcare Ltd group. Woodhaugh provides rest home care for up to 70 residents. On the day of audit, there were 39 rest home residents and three short term-care residents. The facility is managed by an experienced aged care registered nurse (RN) and is supported by two part-time registered nurses. The facility is appropriately staff throughout the 24-hour period. Residents and families interviewed were complimentary about the care and service received.

There are improvements required around aspects of pain management, integration of allied health professional assessments into the care plan, prescribing of ‘as required’ medication, GP reviews of medication charts and review of activity care plans.

## Audit Summary as at 17 February 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 17 February 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 17 February 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 17 February 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 17 February 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. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 17 February 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. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 17 February 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 17 February 2014

### Consumer Rights

Policies and procedures are in place that meets with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the nationwide advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Care plans accommodate the choices of residents and/or their family/whānau. Discussions with families identified that they are fully informed of changes in their family member’s health status. Annual staff training reinforces an understanding of residents’ rights and their ability to make choices. Complaints processes are implemented; complaints and concerns are actively managed with all associated documentation together in complaints register.

### Organisational Management

The service has an established and implemented quality and risk systems that include analysis of incidents, infections and complaints, internal audits and feedback from the residents. Key components of the quality management system link to monthly staff meetings. Corrective actions are implemented, documented and followed through to compliance. Cressida Healthcare Ltd has a strategic execution plan January –December 2014 and a quality and risk management plan 2014 that aligns with the strategic plan. The core purpose and core values identified in these documents sets out the vision and values of the service. Woodhaugh holds monthly quality and risk and staff meetings. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.

### Continuum of Service Delivery

The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The GP completes three monthly reviews.

The residents' needs, objectives/goals have been identified in the long-term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. Residents and families interviewed state their needs are being met appropriately and they are involved in the care planning process. There is an improvement required around pain management and integrating allied health professional assessments into the resident care plan.

The activity programme is resident focused and provides a variety of activities to meet the interests and abilities of the consumer group. Community links are maintained. Improvements are required around co-ordinating the review of activity plans at the same time as the clinical care plan.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around ‘as required’ prescribing to include an indication for use and three monthly GP reviews of medication charts.

All meals and baking is prepared and cooked on site. The menu is reviewed by the company dietitian. Resident’s individual food preferences, dislikes and dietary requirements are met. All staff have received training in food safety and hygiene.

### Safe and Appropriate Environment

Woodhaugh rest home is a well maintained home with on-going interior refurbishment. The environment is homely and comfortable with suitable furnishings. The grounds and gardens are easily accessible and shaded seating. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised and have a hand basin. Six bedrooms have ensuites. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. There are two communal dining and lounge areas that encourages social interaction within the rest home. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

### Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers. The service currently has no residents assessed as requiring restraints or enablers. Restraint is an agenda item at monthly staff meetings. Staff have received training in restraint minimisation.

### Infection Prevention and Control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors and has been reviewed January 2014. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and in annual training plan. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to staff at staff meetings. The service graphs infections and displays them on the nurses’ station wall.

# 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:** | Cressida Otago Limited |
| **Certificate name:** | Cressida Otago Limited |

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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:** | Woodhaugh Rest Home |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 17 February 2014 | **End date:** | 18 February 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:** | 42 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 12 | **Hours off site** | 10 |
| **Other Auditors** | XXXX | **Total hours on site** | 12 | **Total hours off site** | 8 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 3 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 21 | Total audit hours | 45 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 31 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **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:

|  |  |  |
| --- | --- | --- |
| 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 Friday, 14 March 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Woodhaugh is part of the Cressida Healthcare Ltd group. Woodhaugh provides rest home care for up to 70 residents. On the day of audit, there were 39 rest home residents and three short term-care residents. The facility is managed by an experienced aged care registered nurse (RN) and is supported by two part-time registered nurses. The facility is appropriately staff throughout the 24-hour period. Residents and families interviewed were complimentary about the care and service received. There are improvements required around aspects of pain management, integration of allied health professional assessments into the care plan, prescribing of ‘as required’ medication, GP reviews of medication charts and review of activity care plans.  |

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| **Outcome 1.1: Consumer Rights** |
| Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the nationwide advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Care plans accommodate the choices of residents and/or their family/whānau. Discussions with families identified that they are fully informed of changes in their family member’s health status. Annual staff training reinforces an understanding of residents’ rights and their ability to make choices. Complaints processes are implemented; complaints and concerns are actively managed with all associated documentation together in complaints register. |

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| **Outcome 1.2: Organisational Management** |
| The service has an established and implemented quality and risk systems that include analysis of incidents, infections and complaints, internal audits and feedback from the residents. Key components of the quality management system link to monthly staff meetings. Corrective actions are implemented, documented and followed through to compliance. Cressida Healthcare Ltd has a strategic execution plan January –December 2014 and a quality and risk management plan 2014 that aligns with the strategic plan. The core purpose and core values identified in these documents sets out the vision and values of the service. Woodhaugh holds monthly quality and risk and staff meetings. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Resident records are integrated and support the effective provision of care services. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.  |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The service has a policy for admission and entry for the rest home. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and the admission agreement are discussed with them. The registered nurse is responsible for each stage of service provision. Assessments and care plans are developed and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The GP completes three monthly reviews.The residents' needs, objectives/goals have been identified in the long-term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. Residents and families interviewed state their needs are being met appropriately and they are involved in the care planning process. There is an improvement required around pain management and integrating allied health professional assessments into the resident care plan. The activity programme is resident focused and provides a variety of activities to meet the interests and abilities of the consumer group. Community links are maintained. Improvements are required around co-ordinating the review of activity plans at the same time as the clinical care plan. Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. There are improvements required around ‘as required’ prescribing to include an indication for use and three monthly GP reviews of medication charts. All meals and baking is prepared and cooked on site. The menu is reviewed by the company dietitian. Resident’s individual food preferences, dislikes and dietary requirements are met. All staff have received training in food safety and hygiene.  |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Woodhaugh rest home is a well maintained home with on-going interior refurbishment. The environment is homely and comfortable with suitable furnishings. The grounds and gardens are easily accessible and shaded seating. The building has a current building warrant of fitness and fire service evacuation approval. All rooms are personalised and have a hand basin. Six bedrooms have ensuites. There is adequate room for residents to move freely about their bedrooms and communal areas using mobility aids. There are two communal dining and lounge areas that encourages social interaction within the rest home. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers. The service currently has no residents assessed as requiring restraints or enablers. Restraint is an agenda item at monthly staff meetings. Staff have received training in restraint minimisation. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors and has been reviewed January 2014. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and in annual training plan. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to staff at staff meetings. The service graphs infections and displays them on the nurses’ station wall.  |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 2 | 1 | 0 | 0 |

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

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Five of five permanent resident files identify pain. There is no pain assessment in place for two resident files sampled that identify pain as per the GP medical notes. Another two residents have not had a review of their pain assessments; therefore the long term care plan does not accurately reflect the resident’s pain status. There is no monitoring of the effectiveness of pain for two of five residents who identify pain. ii) One respite resident has unexplained collapses as per the medical notes and poses a high falls risk as documented in the physio notes. The medical problem and falls risk has not been identified in the respite short term care plan or falls risk assessment.  | Ensure pain assessments and pain monitoring is in place for all residents who identify with pain. ii) Ensure all available information is gathered to complete the respite care short term care plan on admission.  | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The activity plans are not reviewed at the same time as the clinical care plans.  | Ensure activity plans are reviewed at the same time as the clinical care plans. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative 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 | Five out of 14 medication charts did not have the indications for use of prn medications ii) Four out of 15 medication charts did not evidence GP review three monthly.  | Ensure all prn medications have an indication for use documented on the medication chart. ii) Ensure the GP reviews the medication chart three monthly.  | 60 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. The staff orientation programme includes the Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers' Rights. Two caregivers, one registered nurse and activity coordinator interviewed could discuss how consumer rights are met during service delivery and gave examples such as privacy, choice and independence. Training on Code of Rights was provided January 2014. |

##### **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:** |
| Residents Rights information is available and posters are placed on walls around facility. The code of rights and advocacy pamphlets are located in the lounge off the main entrance. The Code of Health and Disability Consumers' Rights (COR) is available in formats appropriate to the communication preferences or needs of residents. E.g. large print, tapes and videos. On admission, the nurse manager or registered nurse discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Residents (four) stated they were well informed about the COR and the manager provides an open-door policy for concerns/complaints.D6,2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission |

##### **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:** |
| The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records.Discussions with residents (four) and family member (three) identified that personal belongings are not used as communal property.During the visit, staff demonstrated gaining permission prior to entering resident private areas. There were no instances of private information being visible to the public. Interviews with four residents and three family members identified that caregivers always respect residents' privacy. Residents are supported to attend their own church in the community. There is a Sexuality and Intimacy policy. Sexuality and spirituality in service was provided to staff January 2013.There is an Abuse and Neglect policy. Elder Abuse & Neglect training was provided in June 2012. Review of incident accident forms and discussions with management, registered nurse and two caregivers identified that there have been no incidents of abuse or neglect and they could describe situations that would be considered abusive or neglectful.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. D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Residents are addressed by their preferred name. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a culturally appropriateness policy that cover the guiding principles for cultural safety for Maori and their whanau. Through the admission and assessment process, cultural needs/requirements are identified on an individual basis. Resident care plans identify the cultural needs, religious values and beliefs of the resident. Care planning is completed in conjunction with the resident and their whanau if appropriate. The service's philosophy of care results in each person's cultural needs being considered individually. External specialist advice is available when necessary. The service is able to access interpreter services from the Dunedin hospital if required.There is currently one resident who is a Maori; however, the resident does not want to be treated any different from other residents. A3.2 There is a Maori health plan that includes a description of how the service will achieve the requirements set out in A3.1 (a) to (e).Cultural awareness in-service has been provided to staff January 2014.  |

##### **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:** |
| D3.1g The service provides a culturally safe service by implementing the Woodhaugh philosophy that focuses on residents' right to be treated as an individual with dignity and respect. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Expressing spirituality, intimacy and culture is documented in the care plan. In-service was provided January 2014. Families interviewed (three) confirmed they are actively encouraged to be involved in their relative's care in whatever way they want, for example, taking them to appointments or outings. They are able to visit at any time of the day and are actively encouraged to participate in the resident reviews.D4.1c Seven care plans reviewed include the resident's social, spiritual, cultural and recreational needs. Interventions to support these are identified and evaluated. |

##### **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:** |
| Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. All six staff files included a signed copy of the Code of Conduct. Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Staff have been provided with training in regards to professional boundaries in February 2013.  |

##### **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:** |
| A2.2 Services are provided at Woodhaugh that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. There are monthly staff meetings that include; complaints/compliments, training, restraint, incidents and accidents, infection control, quality improvement, H&S, and general business. Four residents and three families interviewed spoke positively about the care provided.D1.3 all approved service standards are adhered to.D17.7c There are implemented competencies for caregivers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. Professional boundaries are discussed as part of the orientation to the service. The service supports and encourages staff to attend education both internally and externally. |

##### **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:** |
| Discussions with four residents and three family members all stated they were welcomed on admission and were given time and explanation about services at Woodhaugh rest home. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs. Interpreters are available through the DHB.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. Four resident files reviewed included completed admission agreements.D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.D16.4b A review of 12 incident forms in January 2104, it was noted that in all incidents the family have been informed, three family members interviewed stated they are always kept informed. Documentation of family contact is recorded on communication page in resident file. Open disclosure in service was provided to staff January 2014.D11.3 The information pack is available in large print and advised that this can be read to residents. This information is available the lounge at front entrance to Woodhaugh. |

##### **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:** |
| There is an Informed Consent and Advanced Directives policy. Information on informed consent is included in the information pack and discussed with residents and families at time of admission. A review of a sample of seven resident files identified that informed consent is collected for photos, health information and outings as part of the admission agreement. There is a resuscitation form and process. Seven files reviewed had advanced directive forms (DNR forms) appropriately completed and signed by resident. Informed consent training has been provided to staff in December 2013.D13.1: there were seven admission agreements sighted and all seven had been signed.D3.1.d: Discussion with three family identified that the service actively involves them in decisions that affect their relative’s 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:** |
| Resident right to access advocacy services is identified for residents. Leaflets are available at the entrance of Woodhaugh rest home. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. D4.1d; Discussion with four residents and three family members identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services. |

##### **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:** |
| Family members and residents confirm that visiting can occur at any reasonable time. This is stated in the resident information book. D3.1h Discussion with three family confirm that they are encouraged to be involved with the service and careD3.1.e discussion with four staff (two caregivers, activities coordinator and registered nurse), four residents and three family members confirm that they are supported and encouraged to remain involved in the community and external groups such as school or kindergarten children visit. |

##### **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:** |
| The service has a complaints policy and process for making complaints and this is communicated to residents/family/whānau. Residents (four) and family members (three) confirmed that concerns are actioned immediately. There is a complaints register for complaints verbal and written. Evidence of discussions and letters of follow up with complainants are maintained on file. There was evidence in staff meeting minutes of feedback to staff of complaints and concerns and the necessary corrective actions.D13.3h. a complaints procedure is provided to residents within the information pack at entry. Complaints information is included in the resident’s information book. |

##### **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:** |
| Woodhaugh currently provides care for up to 70 residents at rest home level care. On the day of the audit, there were 42 residents in total (39 rest home residents and three residents receiving respite care). Cressida Healthcare Ltd (includes Woodhaugh) has a strategic execution plan January –December 2014 that includes (but is not limited to): core values; core purpose; target market customer description; target market customer's greatest needs; key benefits; three-five year strategic moves; numerical targets; strengths, weaknesses, opportunities and threats; one year action priorities; 90 day goal; 90 day action priorities; key performance indicators. The stated core values are: 'compassionate; open to change (innovate); trustworthy; exceptional care; we listen, we act' and the stated core purpose is 'we provide exceptional care in loving and trusting environments'. A documented philosophy explains how this is achieved in practice. The service is managed by an experienced facility manager (registered nurse) who is supported by two other registered nurses. Woodhaugh has established quality and risk management systems. A range of quality data is collected analysed and communicated to staff via the staff meetings. This data included (but not limited to): a) Incidents and accidents and near misses, b) Infections, c) Complaints and concerns, and d) Hazards.  |

##### **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:** |
| The service is managed by an experienced aged care facility manager (registered nurse) who has been in this position for two years. She has more than 20 years’ experience in caring for elderly people both as a nurse and as a manager. The nurse manager is supported by two further registered nurses, one of who assumes responsibility in the manager’s absence. |

##### **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:** FA |
| **Evidence:** |
| The service has an established quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. An internal audit schedule is implemented. There is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and at handover times. D19.3: There are implemented health and safety policies that include hazard identification. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The service has extra supplies of food, water and equipment available in the event of a disaster. There is an infection control manual, infection control programme and corresponding policies, which require inclusion of antibiotic resistant infections. There is a restraint minimisation management policy. There is currently no residents using restraint or enablers. There is an annual staff-training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the nurse manager who completes the follow up, collates and analyses data to identify trends. Results are discussed with staff through the monthly staff meeting. All residents and families are surveyed each year (June 2013) as evidenced on review of survey forms and evaluations. Surveys are evaluated and reviews conducted to identify corrective actions. Survey questions include meals, activities, medical and nursing care, privacy and care staff. D19.2g Falls prevention strategies such as falls assessments, sensor mats, exercise sessions. Falls prevention in-service was provided – October 2013. |

##### **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:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
| Ensure survey results are collated.  |
| **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:** 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 1.2.3.9 (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. Staff can describe the incident reporting process and their role. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. A monthly analysis of incidents occurs. Twelve incident forms reviewed (one challenging behaviour, seven falls, three near miss events and one property damage event) included corrective actions and demonstrate the family had been notified. Family interviews (three) confirmed that they were notified of accidents and incidents. Open Disclosure is included in policy/procedure. Staff are aware of the requirement to notify statutory authorities. |

##### **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 job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. The service has a staff orientation programme established. Completed orientation checklists are on files and staff described the orientation programme. An annual training plan is scheduled and includes: Open disclosure, resident rights and responsibilities, complaints, boundaries-January 2014; First aid-February 2013; Chemical awareness, Infection control, May 2013; skin management, food handling, infection control-June 2013, Observations and monitoring-July 2013; Fire evacuation –August 2013; Falls management, Diabetes-October 2013; Challenging behaviour, Anxiety and Depression, Bi Pap Machine, end of life, pain management-November 2013; informed consent, continence-December 2013; cultural awareness, Maori health policy-January 2104; restraint, privacy of information, sexuality and intimacy, medication competency-February 2014; The service has annual practising certificates for all health professionals involved in the delivery of care at Woodhaugh. The service has completed annual performance reviews for all staff. Individual records of training are maintained.D17.7d: The facility manager have maintained at least eight hours annually of professional development. |

##### **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:** |
| There is a staffing policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Interviews with the registered nurse and two caregivers, four residents and three family members identify that staffing is adequate to meet the needs of residents. Facility manager (registered nurse) Monday-Friday 08.00-16.30 plus on call every day. Registered nurse coverage of at least 5.5 hours Monday -SaturdayAllied health professionals (including occupational therapist, physiotherapist and dietitian) are contracted on an 'as required' basis.AMMonday-Sunday 2x caregiver 07.00-15.00; 2x caregiver 07.00-13.00PMMonday-Sunday 2x caregiver 15.00-23.00; 2x caregiver 15.30-21.30NightMonday-Sunday 2x caregiver 23.00-07.00 ActivitiesMonday-Thursday 1x activities officer for 5 hours per day plus flexible as required.KitchenMonday-Sunday Cook 8-3.30pm. Caregivers are responsible for cooking and serving evening meals.CleaningMonday-Friday 2x cleaner 09.00-12.00.Saturday-Sunday 1x cleaner 09.00-12.00.1x maintenance person Monday, Wednesday and Friday for 6 hours per day plus flexible as required, and attends to laundry duties. |

##### **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:** |
| The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being stored securely in the staff office. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Archived information is secured in a locked cupboard and is able to be accessed if required. D7.1 Entries are legible, dates and signed by the relevant caregiver or RN including designationIndividual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |

##### **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:** |
| There is a documented admission policy. All residents have a needs assessment service coordination approval prior to entry to the service. All potential residents receive an information pack on enquiry. The information pack includes all relevant aspects of service and residents or family/whānau are provided with associated information such as the H&D Code of Rights,' complaints’ information and advocacy. A suitable time for admission is arranged with the RN and resident/family/whanau for planned admissions. The registered nurse (RN) admits oncology patients on the Sundays as required. The service has an emergency respite contract and there is an RN (facility manager or RN) available on call for admissions. D13.3 The admission agreement reviewed aligns with a) –k) of the ARC contract. Five of five permanent rest home resident admission agreements sighted had been signed. Two of two respite oncology patients have signed a short-term care agreement. 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. Four residents and three relatives interviewed had received all the required information. |

##### **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 service has an accepting/declining to service policies. Where a resident is declined entry the referral agency and potential resident and or family/whanau would be informed of the reason for declining entry and should this happen referred back to the referring agency and alternative health care / residential care services will be sought. The service has not had to decline any clients. Reasons for declining entry would be if the level of care could not be provided by the facility or there are no beds available.  |

##### **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: Five out of five rest home resident files sampled identified that an RN completed an initial assessment within 24 hours. Two respite care residents had a short term nursing care plan for respite care completed on admission (link 1.3.6.1). The registered nurse (RN) completes an assessment within 24 hours of a resident admission to the service. This then serves as a basis for the initial care plan (short-term care plan) for long-term residents. The initial care plan evolves over a three-week period. The long-term resident centred care plan is developed within three weeks in five of five long-term resident files sampled. Development of the long-term care plan is in consultation with the resident/ family/whanau and caregivers. Assessment, planning, evaluation and review are undertaken by the RN with input from allied health professionals and healthcare assistants (HCAs). Service delivery is undertaken by HCAs under the guidance of the RN and the RN/facility manager. Four residents and three family members interviewed state they are involved in the assessment and planning process. There is documented evidence of resident/family/whanau involvement in the development and review of care plans. The service has contracted four GPs in a local practice to provide medical services to the residents. The GPs visit the home twice a week. A GP round was being conducted on the day of audit. The GP (interviewed) states the RN is always ready for the GP round with notes and medication charts ready for review. There is good communication between the RNs and the practice. GPs have confidence in the RN clinical assessments and the GPs will visit at the RN request when required. There is evidence of GP discussion with residents and family regarding resuscitation status and end of life care as documented in the medical notes. The GP examines residents within 48 hours of admission. Residents new to the service enrol with the GP practice. Residents and relatives interviewed are positive about the GP service. D16.5e There is documented evidence in five of five permanent resident files sampled that the GP had seen the resident within two working days. There are weekly visits from the mental health nurse practitioner to follow-up residents under the care of mental health clients. Early warning and signs and symptoms and crisis plan is developed and reviewed as required. The mental health team respond to any concerns promptly. Four of four permanent residents interviewed state they are aware of the services provided. All seven resident files (including two respite cares) included a family\whanau/friend/agent communication form that documents discussion held with family including accidents/incidents, infections, GP visit, appointments, transfer to hospital, care plan review and any changes to health status. Family members confirmed they are kept informed by any changes to resident health. The resident's file and is available to specialists, allied health professionals and all staff directly involved in the care of the resident. There is an integrated approach to care and all notes are maintained in the integrated resident file. The staff work in teams for each side of the rest home. There is a “global” verbal handover for all staff. A communication diary is maintained. Significant events and all falls are reported to the RN and documented in progress notes. Progress notes are dated, timed and signed with designation. RN entries are highlighted. Seven resident files were sampled are as follows: 1) respite care resident XXXXX; 2) respite resident XXXXX; 3) resident XXXXX; 4) resident XXXXX; 5) resident XXXXX; 6) resident XXXXX; and 7) resident XXXXX. Tracer methodologyXXXXXX *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:** |
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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 1.3.3.4 (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:** |
| A full RN assessment of the resident is completed on admission and reviewed six monthly. The following personal needs information is gathered during admission which includes but is not limited to personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whānau support, activities preferences, food and nutrition information. The RN assessment forms the basis of the initial care plan developed within 24 hours of admission. The diversional therapist completes an activity assessment within three weeks of admission of new resident. There is a range of risk assessment tools available for use including (but not limited to); Waterlow pressure area risk assessment, coombes falls assessment, mobility assessment, cultural needs assessment tool, continence, dietary requirements, pain assessments (link 1.3.6.1) and wound assessment (where appropriate). The GP assesses the resident within 48 hours of admission. Notes by GP and allied health professionals are evident in resident’s files, communication with families and notes as required by the registered nurse.  Families interviewed are very supportive of the care provided and express that the needs of their family member are being met. |

##### **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:** FA |
| **Evidence:** |
| Residents’ centred care plans are individualised and promote continuity of service delivery. An initial assessment forms the basis of an initial care plan within the first 48 hours to guide staff in the safe delivery of care during the first three weeks of their admission. The RN develops a long-term resident centred care plan from information gathered over the first three weeks of admission. Long-term resident centred care plans are documented and reviewed by the registered nurse six monthly. There is evidence of resident/family/whanau input into the care planning process. Five out of five permanent rest home files sampled include a current care plan. The two respite care residents have short-term care plans in place (link 1.3.6.1). Residents’ care plans are individualised and promote continuity of service delivery. Residents' care plans are easy to follow and available for all staff to read and implement. One RN has completed InterRAI training. The other part time RN and RN/manager are scheduled for training in April 2014. Information about each individual resident is located in a main file with assessments and plans, progress notes, GP notes\lab results and other key monitoring forms such as BP and weight. Activity plans include the resident’s goals and methods of achieving the goals. There is evidence of resident/family/whanau input into the activity plan. The activity care plans are not reviewed at the same time as the long-term resident centred care plans (link 1.3.7.1). |

##### **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:** 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 1.3.5.3 (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 Low |
| **Evidence:** |
| Four residents and three relatives interviewed confirm care delivery and support by staff is consistent with their expectations and their needs are being met. Staff use the care plan to ensure continuity of care delivery is maintained. The residents and family members state they are happy with the care provided and they state communication with the manager, the registered nurse, HCAs and GPs is open and honest at all times.HCAs are kept informed of the requirements of residents during daily “global” shift handovers, via the communication diary and are asked for feedback during the development of long-term care plans, and as part of the six monthly care plan review. This was confirmed by two HCAs interviewed. Caregivers inform the RN promptly if there are any changes to resident’s health status. The RN conducts a clinical assessment and initiates a GP review as required. Dressing supplies are available. There is currently one wound being managed and treated. There is a wound assessment tool and wound care plan in place. There are no pressure areas. There is evidence of a wound care nurse and district nursing involvement (compression therapy) for leg ulcers that have now healed. Continence products are available and resident files identify the type of product required for day use, night use and other management. Specialist continence advice is available as needed by RN referral.Resident weight is monitored monthly or more frequently to monitor unintentional weight loss. In two of two resident files sampled with weight loss the GP is aware (medical notes sighted) and a short-term care plan is in place with interventions including high protein foods, dietary supplements (sustagen) and review of dietary requirements. A food intake monitoring chart is sighted in use. There is an improvement required around pain management and respite care plans. |

##### **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 Low |
| **Evidence:** |
| Four residents and three relatives interviewed confirm care delivery and support by staff is consistent with their expectations and their needs are being met. Staff use the care plan to ensure continuity of care delivery is maintained. Caregivers inform the RN promptly if there are any changes to resident’s health status. The RN conducts a clinical assessment and initiates a GP review as required.  |
| **Finding:** |
| Five of five permanent resident files identify pain. There is no pain assessment in place for two resident files sampled that identify pain as per the GP medical notes. Another two residents have not had a review of their pain assessments, therefore the long term care plan does not accurately reflect the resident’s pain status. There is no monitoring of the effectiveness of pain for two of five residents who identify pain. ii) One respite resident has unexplained collapses as per the medical notes and poses a high falls risk as documented in the physio notes. The medical problem and falls risk has not been identified in the respite short term care plan or falls risk assessment.  |
| **Corrective Action:** |
| Ensure pain assessments and pain monitoring is in place for all residents who identify with pain. ii) Ensure all available information is gathered to complete the respite care short term care plan on admission.  |
| **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:** PA Low |
| **Evidence:** |
| The service employs a qualified diversional therapist (DT) for 25 hours per week to plan and implement an activity programme Monday to Friday. The plan is developed a month in advance and is available in large print on the notice boards throughout the facility. The residents reach a copy. Movies and self-directed activities occur in the weekends and activity resources are readily available for HCAs to access for resident activities. There is a dining room and large in each end of the rest home and other small areas where activities can take place. One on one activity is scheduled for residents who choose not to participate in group activities. Activities on the programme include (but not limited to); news and views, exercise and walking group, word games, trivia, cards group, carpet bowls, baking group, housie and happy hour. There are weekly entertainers or community visitors such as a writer sharing reminiscence in stories, piano players, singers and concerts. Day-care residents are included in the programme. Currently there are no volunteers involved in the programme. Reading is a favourite past time of many of the residents and there is a visiting library service provided for the residents. Festive occasions and birthdays are celebrated. A taxi/mobility van is hired for outings to community and rest home functions such as the Octagon Club, stroke club and rest home games. The DT has a current first aid certificate. Residents have an opportunity to provide feedback on the programme at their three monthly meetings, which are held with an age concern representative (residents advocate).The DT completes a resident assessment and activity for a new admission within three weeks. The care plan is evaluated every six months or earlier if there are changes to the resident’s recreational needs. The activity plan is not reviewed at the same time as the care plan review.  |

##### **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:** PA Low |
| **Evidence:** |
|  The DT completes a resident assessment and activity for a new admission within three weeks. The care plan is evaluated every six months or earlier if there are changes to the resident’s recreational needs. The activity plan incorporates the resident’s goals and methods of achievement of those goals.  |
| **Finding:** |
| The activity plans are not reviewed at the same time as the clinical care plans.  |
| **Corrective Action:** |
| Ensure activity plans are reviewed at the same time as the clinical care plans. |
| **Timeframe (days):** 180 *(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:** |
| Evaluation timeframes are specified in policies and procedures. Evaluations are conducted by the registered nurse six monthly or when a resident's condition alters. All five long care plans for permanent residents sighted on the day of the audit were evaluated according to policy timeframes. Care staff monitor resident's progress on a shift-by-shift basis and report any concerns to the Manager or RN. Six monthly multidisciplinary meetings are held with involvement from the RN, GP, recreational staff, pharmacist, key HCA and any other allied health professional included in the care of the resident. The written evaluations include any concerns/input the family may have. Short term care plans are used for short term or acute needs. Short term care plans sighted are for falls, low sodium and weight loss. The short term care plans have been evaluated regularly and the problem resolved or added to the long term care plan as an on-going problem. The service has developed a checklist to ensure the short term care plans for respite care residents is reviewed for each episode of care. D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. D 16.5 c (iii) Five of five activity plans were not evaluated at the same time as the care plan. (Link 1.3.7.1). There is a general practitioner review every three months and on an as required basis.  |

##### **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:** |
| There is a documented policy on referral to other health care services. When a resident requires a referral to another service, the GP or RN take responsibility for this duty. An explanation is given to the resident and their family/whanau are informed as appropriate and offered options for referrals. Referrals sighted in the resident files sampled include; mental health team, wound specialist, orthopaedics, dietitian, podiatrist and physiotherapist. D16.4c; The service provided an example of where a residents wound had changed and a referral was sent to the Wound Care Specialist.D 20.1 Discussions with registered nurse identified that the service has access to GP, occupational therapist, physiotherapist, podiatrist, dietitian, wound care nurse specialist, continence, infection control nurse and other allied health professionals as required.  |

##### **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 are documented and implemented and procedures for transition, exit, discharge or transfer. Residents are re-assessed when higher level of care is required. Consultation regarding the transfer, with the resident, family, GP and other relevant persons occurs. DHB transfer forms are utilised and completed by the Manager or RN. On transfer to hospital, the service uses the yellow envelope system developed in conjunction with secondary services. This contains a copy of all relevant information (but not limited to) referral form, observation chart, GP/RN notes, medication charts and resuscitation form.  |

##### **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:** |
| Policies and procedures on medicine management include prescribing and dispensing, self-administration, storage and disposal, staff administration, controlled drugs, staff training and competencies and monitoring medication errors. The robotic medication administration system has been implemented. The RN completes a reconciliation and medication audit for all robotic rolls on delivery. The pharmacy delivers pharmaceuticals daily as required and collects returns. There is a current list of RN’s and medication competent HCAs. Medication competencies and education (March 13) is completed annually. The pharmacy is available for advice and support, as and when required. The medication room for controlled drugs is separate to the main medication room. The there is a locked controlled drugs cabinet within a locked room. There are weekly stock checks of controlled drugs. The pharmacy completed a six monthly audit February 2014. There are two locked medication trolleys (one for each side of the home). All eye drops in use are dated. Standing orders are not used. PRN medications are dispensed in blister packs and there is a system for checking expiry dates. Controlled drugs are signed by two medication competent staff on the signing sheet. The medication fridge is being monitoring however, there is no evidence of corrective actions for temperatures outside of the acceptable range. The medication fridge monitoring form (corrected on the day of audit) includes corrective actions required for temperatures outside of the normal range. The medication folder contains an adverse reaction flow chart and a diabetes flow chart. There is one self-medicating resident. There has been a self-medication consent and assessment signed by the resident and RN. There is evidence of a six month review. There is a self-medicating monitoring form that is checked to ensure the resident is taking the medication as prescribed. 14 medication charts sampled had regular medications correctly prescribed. The charts are clear and easy to read. 14 of 14 medicine charts sighted include a photograph of the resident for identification purposes and allergies/adverse reactions noted. 'No Known Allergies' (NKA) are also recorded. There is an improvement required around the prescribing of prn medications to include indication for use and GP review of medication charts three monthly. D16.5.e.i.2; Four out of 14 medication files sampled did not identify the GP had reviewed the resident medication charts three monthly.  |

##### **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:** |
| 14 medication charts sampled had regular medications correctly prescribed. The charts are clear and easy to read. 14 of 14 medicine charts sighted include a photograph of the resident for identification purposes and allergies/adverse reactions noted. 'No Known Allergies' (NKA) are also recorded.  |
| **Finding:** |
| Five out of 14 medication charts did not have the indications for use of prn medications ii) Four out of 15 medication charts did not evidence GP review three monthly.  |
| **Corrective Action:** |
| Ensure all prn medications have an indication for use documented on the medication chart. ii) Ensure the GP reviews the medication chart three monthly.  |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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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 1.3.12.5 (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:** |
| The service employs a qualified chef Monday to Friday and a weekend cook. The chef plans the company menu and the dietitian reviews the menu (February 2014).The HCAs prepare breakfast. The main meal is midday and the HCAs heat and serve the semi-prepared evening meal. The chef receives a dietary requirements form for all new admissions and respite care residents and is informed of any resident dietary changes. Normal and soft/smooth meals are provided and alternative meal choices for known dislikes are offered. Currently there are no special dietary requirements. All meals are prepared and cooked in the main kitchen. Cooking temperatures are monitored twice daily. Food is held in bain maries and temperatures are checked prior to serving. Food is delivered to the second kitchenette in a bain marie. There are snacks available at any other time for residents. The chef is aware of any residents with weight loss and provides high protein foods and sustagen. Fridge, chiller and freezer temperatures are monitored and recorded twice daily. All food items in the fridges and chiller are dated. Kitchen equipment is checked and tagged (January 2014). Staff are observed wearing appropriate protective clothing. All chemicals are stored in a locked room. Safety data sheets are readily available. Staff have attended chemical safety training. The chef trains the staff including HCAs in food safety and hygiene training. .Four residents interviewed state they enjoy the meals provided and their preferences are met. They have the opportunity to provide feedback on the food service at the resident meetings. The chef interacts with the residents at meal times and receives verbal feedback from residents in both dining rooms.  |

##### **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:** |
| Policies and procedures are in place and implemented for the safe and appropriate storage and disposal of waste and hazardous substances. There is a body and blood fluids policy and an exposure to blood or body fluids policy, which includes needle stick management, and a transmission, based precautions policy. The service has an emergency plan for the management of waste and hazard incidents or accidents. There is an accident/incident system for investigating and recording all incidents. All completed forms are reviewed by the manager. Staff are aware of their responsibilities relating to reporting and recording any incidents as confirmed on interview with two caregivers and one cleaner/laundry person. On audit day, staff were observed wearing appropriate protective equipment including aprons, gloves and goggles. Chemicals are stored in the locked laundry room. Chemical bottles sighted have correct manufacturer labels. Safety Data Sheets (MSDS) are available for all chemicals used and outline appropriate first aid procedures. Training in the management of waste, chemical safety and hazardous substance occurs at orientation and on an on-going basis. General waste is disposed of into a skip bin that is collected weekly by an external contractor. An approved container is used for the safe disposal of sharps. Food scraps are disposed of in the insinkerator.  |

##### **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:** |
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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 1.4.1.6 (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:** FA |
| **Evidence:** |
| A current Building Warrant of fitness is displayed and expires 18/2/2015. The facility is divided into wings and there is an upstairs area that is used for family to stay while their relative is undergoing treatment at the hospital. There are stairs or lift access to the Gables (12 beds). Rest home wings are Millhouse (17 beds), Homestead and Villa (28 beds) and Inverleigh (13 beds). There has been painting and decorating of bedrooms and replacement of carpet as required. On-going refurbishments are planned. There is a maintenance person employed for 25 hours per week. Staff use a maintenance request form for repairs, which are addressed and signed off. Contractors are available for larger repairs such as plumbing and electrical repairs. There is a monthly, quarterly and annual maintenance plan. Monthly maintenance includes (but not limited to); fire testing, water temperature monitoring, call bell testing, wheelchair checks There are staff amenities. Each end of the home has a spacious lounge and dining room. There are quiet areas throughout the facility for resident and visitors to meet that provide privacy when required. The conservatory area that provides a view of the roads has one way glass panels to provide privacy. There are outside areas that are easy to access for residents and family/whanau members. These include outdoor shade, tables and chairs. D15.3d; The lounge areas is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge on the day of the audit.ARC D15.3; There is sufficient equipment available.  |

##### **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:** 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 1.4.3: 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:** |
| The facility has 70 single bedrooms. All bedrooms have hand basins. Six bedrooms have ensuites. There are adequate numbers of communal showers and toilets at the facility with privacy curtains. Flooring in bathrooms and toilets is of a non-slip surface and easily cleaned. Appropriate signage, vacant/engaged and privacy locks on doors were sighted. Hand washing and drying facilities are located in all service areas and toilets. Staff (including caregivers, kitchen, and laundry/cleaning staff) interviewed confirm they have access to adequate hand washing facilities throughout the facility. |

##### **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:** |
| Bedrooms are of an adequate size appropriate to the level of care provided. The rooms allow for the residents to move about the room independently with the use of mobility aids. There is adequate space to manoeuvre a hoist if required. The rooms observed are personalised with the resident’s belongings. Residents interviewed (four) confirm their bedrooms are spacious and they can personalise them as desired. Family/whanau interviewed confirmed they are happy with their family member’s bedroom.  |

##### **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:** |
| There are two lounges and two dining rooms (one at each end of the home). The two communal lounges have comfortable and appropriate seating that is placed to allow for group and individual activities to occur. Staff assist residents to access communal living areas, as observed on the day of the audit. Residents can use their bedrooms or the outdoor areas, if they require privacy at any time. Staff are observed knocking on residents' doors prior to entering. Four residents interviewed confirm there are a number of internal and external areas they are able to access for relaxation and staff assist them to access the lounge and the dining room. |

##### **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:** |
| Residents are provided with safe and hygienic cleaning and laundry services. The service has two cleaners on per day. One cleaner has laundry duties into the schedule. The service undertakes all laundry service on site. Policies and procedures on cleaning and laundry services are documented and implemented. Laundry and cleaning processes are monitored for effectiveness through internal and external audits and resident meetings. There is a designated area within the laundry for the storage of cleaning chemicals and the laundry is locked when not in use. Protective wear is available including gloves, aprons and staff are observed wearing these on the day of audit. The laundry has hand-washing facilities that comply with infection control requirements. There is a cleaning schedule for the laundry. Maintenance complete the high cleaning. The laundry trolley is well equipped and stored safely after use.  |

##### **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:** |
| D19.6: There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies according to the needs of the residents in the service and how the service will manage in a worst case scenario event. Civil defence supplies include adequate water and food for 3 days. There is a barbeque. Education in emergency management and fire safety is on-going. Interviews with two HCAs and one RN confirm staff are aware of emergency and security procedures. There is an approved fire evacuation scheme. Fire drills are conducted six monthly and staff interviewed confirm they have attended fire drills. 21 staff have a current first aid certificate and there is a first aider on duty across 24 hours. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells are tested monthly. All staff are aware of the emergency process. Residents are orientated to the call bell system on admission to the facility. Security policies and procedures are documented and implemented by staff.  |

##### **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:** |
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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 1.4.7.3 (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:** |
| The facility provides adequate natural light, ventilation and heating for residents, staff and visitors. All resident communal areas are by heat pumps and bedrooms are individually heated with heating panels. Four residents interviewed confirm that an appropriate temperature is maintained throughout the facility.  |

##### **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 established restraint minimisation and safe practice policies and procedures applicable to the size and type of the service. The restraint policy is a no restraint approach with the only exceptions being circumstances where there is imminent danger of residents or others. The restraint co-ordinator (the facility manager) has a job description for the role.The restraint policy includes; a) philosophy/purpose, b) definitions, c)voluntary restraint use, d) guidelines for the use of restraints, e) monitoring of restraint when in use, f) risk and quality management, g) used restraints, h) management of challenging behaviour policy, and i) appropriate documentation (templates/forms).The service restraint policy requires that an assessment of restraint be made involving appropriate health professionals (that is, a registered nurse and general practitioner). Assessment processes are in place to identify risk and to avoid the use of restraint. The policy identifies potential types of restraints, their conditions of use, risks and examples of alternatives/interventions to assist staff to minimise their use. There is a process for the assessment of resident risk associated with the use of restraint. Individual risks are identified on the assessment form if a resident were to require restraint.The restraint policy includes a definition of enablers and procedures for assessment and appropriate use of enablers (that is, voluntary restraint use).Challenging behaviours (November 2013) and restraint minimisation (July 2013) training has been provided to all staff. There was no resident using restraint or enablers on the day of audit. There are appropriate policies to manage restraint should this be required. |

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

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

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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 programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There is an infection control policy and procedures developed by Cressida Healthcare, which are readily accessible to all staff. There is an established and implemented infection control programme. The registered nurse is the Infection Control Coordinator. There is a safety, quality, risk and staff meeting that includes infection control as a standing agenda item. There is discussion and reporting of infection control statistics, infection control matters and consequent review of the programme. Minutes are available for staff. Internal audit for hand hygiene, infection control practices; laundry and cleaning have been completed. Infection Control programme is reviewed annually (January 2014) with management team.Infection Control training has been provided to all staff May 2013, with handover discussions relating to individual residents occurring. The service currently has a respite resident with an infection; staff were able to describe the necessary precautions that were in place.There are linkages with external infection control specialist from Dunedin Hospital. IC Coordinator has completed MOH infection control training in February 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 I.C. coordinator is a registered nurse. The Infection Control team comprises of all staff as part of the monthly staff meeting. Infection Control Coordinator describes accessing the resident’s GP, Dunedin public hospital Infection Control Nurse and SCL if required. The facility manager has access to resident information and laboratory results to assist in managing resident infections. |

##### **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:** |
| There is an infection control manual, which includes policies and procedures appropriate to for the size and complexity of the service.Cressida Healthcare develops the policies with the Woodhaugh infection control officer involved as they relate to the facility and external expertise to ensure they met current infection control guidelines. There are policies and procedures that include but are not limited to a) infection control nurse responsibilities b) antimicrobial usage c) infection control including renovations and construction; d) accidental exposure to blood e) healthcare waste, f) definitions of infections g) outbreak management. Any changes or updates to the infection control policies are notified at the staff meetings. All staff are involved in the implementation of policies. |

##### **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 infection control coordinator, who is the registered nurse, is responsible for coordinating/providing education and training to staff. The staff orientation includes specific training for infection control in particular hand washing and standard precautions. Education records of attendance at infection control training are maintained in the staff education folder. Infection Control is included in the staff orientation. IC Coordinator and Facility Manager have completed MOH IC on line training. The registered nurses have access to the expertise of the infection control nurses at Dunedin Public Hospital and microbiologist at the Southern Community laboratory. Staff individual training records identified orientation included standard precautions and infection control procedures. Infection control training becomes part of the monthly staff meetings and there is documented evidence that IC practices are discussed and evaluated through these meetings. The infection control education in-service is recorded in the general staff meeting minutes May 2013. Information is provided to residents and visitors that are appropriate to their needs and this is documented in medical records. There is alcohol based hand rub readily available. |

##### **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:** |
| There is an infection control surveillance-data gathering and review policy in place, which outlines the purpose and methodology for the surveillance of infections. Infection control data is collated monthly and includes surveillance analysis of multi-resistant organisms associated with anti-microbial use. Surveillance data and analysis was evident in Infection Report Folder. The IC Coordinator, who is the Registered Nurse, has a close liaison with the GP's who closely review infections of their residents and gives feedback as appropriate to the service. Definitions of infections and rates are in place appropriate to the complexity of service provided. Infections are documented on the IC report form per resident. The IC Coordinator summarises the infections each month and provides an IC monthly report, which includes; a) type of infections, b) no of infections, c) identified organisms, d) resolved and unresolved infections, e) infection equation, and f) quality improvement plan. Infections are also graphed monthly. The infection control programme is monitored by surveillance of infections and by infection control audits. Audits completed -Infection Control-May 2013; Laundry August 2013; Cleaning-July 2013; and Hand washing April 2013. Corrective actions are completed and results are reported to the Staff meeting. |

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