# The Kawerau Social Services Trust Board

## Current Status: 28 January 2014

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

## General overview

Mountain View Rest Home continues to provide rest home and hospital level care to a maximum of 50 older people. On the day of audit there are a total of 43 residents, 16 in the rest home and 27 in the hospital. There have been no changes to the service scope or size of the facility or significant changes to staff. Building improvements have occurred since the previous certification audit in 2012.

This unannounced audit revealed three areas requiring improvement. One relates to the analysis of clinical quality indicators and the other two are ongoing improvements required to restraint practice. Six of the eight areas identified for improvement at the previous audit are now resolved.

## Audit Summary as at 28 January 2014

Standards have been assessed and summarised below:

### Key

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

### Consumer Rights as at 28 January 2014

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

### Organisational Management as at 28 January 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 28 January 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 28 January 2014

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 28 January 2014

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

### Infection Prevention and Control as at 28 January 2014

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

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| --- | --- |
| **Legal entity name:** | The Kawerau Social Services Trust Board |
| **Certificate name:** | Mountainview Rest Home |

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| **Designated Auditing Agency:** | DAA Group Ltd |

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| **Types of audit:** | Surveillance Spot | | | |
| **Premises audited:** | 192-202 River Road, Kawerau | | | |
| **Services audited:** | Rest Home, Hospital Care: Medical Services and Geriatric Services | | | |
| **Dates of audit:** | **Start date:** | 28 January 2014 | **End date:** | 28 January 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 43 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 10 | Total audit hours | 26 |

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| Number of residents interviewed | 4 | Number of staff interviewed | 8 | Number of managers interviewed |  |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 75 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## Declaration

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

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of the DAA |  |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise |  |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider |  |
| d) | this audit report has been approved by the lead auditor named above |  |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook |  |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider |  |
| g) | the DAA has provided all the information that is relevant to the audit |  |
| h) | the DAA has finished editing the document. |  |

## Executive Summary of Audit

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| **General Overview** |
| Mountain View Rest Home continues to provide rest home and hospital level care to a maximum of 50 older people. On the day of audit there are a total of 43 residents, 16 in the rest home and 27 in the hospital. There have been no changes to the service scope or size of the facility or significant changes to staff. Building improvements have occurred since the previous certification audit in 2012.  This unannounced audit revealed three areas requiring improvement. One relates to the analysis of clinical quality indicators and the other two are ongoing improvements required to restraint practice. Six of the eight areas identified for improvement at the previous audit are now resolved. |

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| **Outcome 1.1: Consumer Rights** |
| There is an open disclosure policy available to guide staff. Staff interviewed have a good understanding of open disclosure. Staff have all signed confidentiality statements as part of the recruitment process and confidentiality is maintained in a manner consistent with relevant legislation. An improvement from the previous audit in relation to the Aged Related Residential Care Agreement has been addressed.  The service is managing the complaints process effectively. There have been no complaints to the Office of the Health and Disability Commissioner. Some complaints have been notified via Bay of Plenty District Health Board (DHB) and the Ministry of Health. The complaints register contains a clear account of the details for each complaint and how these are acknowledged, investigated and resolved. Residents and relatives have been informed and demonstrate knowledge and understanding about the service complaint management processes. |

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| **Outcome 1.2: Organisational Management** |
| There have been no changes to the governance and management of Mountain View Rest Home since the previous audit in 2012. Quality and risk management systems and processes are being maintained. An improvement required in the way that clinical quality indicators are collated, analysed and shared with all staff. All adverse events are reliably reported and recorded.   Staff are recruited into the service, supported in their professional development and managed effectively. There have been recent adjustments to staffing levels in response to a reduction in resident numbers. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The residents’ records reviewed provide evidence that all residents have been assessed appropriately prior to admission to the facility by the needs assessment service co-ordinators for the Bay of Plenty District Health Board. The provider has implemented systems to assess, plan and evaluate the care needs of the residents. The residents’ needs, outcomes and/or goals set have been identified and appropriate interventions are documented and reviewed on a regular basis with resident and family input. A team approach to care delivery and continuity of service delivery is encouraged. One area of required improvement from the previous audit has been addressed in relation to compliance with timeframes in the service agreement.  Medication management is safely implemented. A visual inspection of the medication system and the lunchtime medication round provided evidence of compliance with respective legislation, regulations and guidelines. The medications records evidence at least three monthly reviews are occurring. Pharmacy input occurs on a regular basis and medication stock checks are completed.  Food services are managed by an experienced food manager. The menus have been reviewed by a registered dietitian and are displayed each day. The individual dietary needs identified during the assessment process for each resident on admission are addressed and choices provided. Special diets can be arranged. Meals are provided at appropriate times of the day.  The activities programme is developed and implemented. Participation is encouraged but is voluntary. Activities are meaningful and the programme reviewed to ensure the interests of the residents are included. Outings in the community are arranged and entertainment is welcomed. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The buildings and chattels are being well maintained. There is a current building warrant of fitness. Improvements to external areas have occurred since 2012. A perimeter fence with electronic entry gate has been installed to increase security. Residents’ access to external areas has been enhanced by the addition of a new deck outside the main dining room and PVC curtains to protect residents from wind have been installed on the deck from the hospital lounge.  The two areas of improvement identified at the previous audit, which were related to surfaces in the hospital sluice room and regular checks of emergency trolleys, are now resolved. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are eight residents requiring restraint interventions on the day of audit and no enablers in use. The two previous areas for improvement which are related to the frequency of monitoring and evaluation are not yet fully implemented and the requirements for improvement are ongoing. |

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| **Outcome 3: Infection Prevention and Control** |
| The service has infection prevention and control policies and procedures relevant to the levels of care provided. The infection control co-ordinator is an enrolled nurse who is supported by an experienced team and the manager of the facility. Surveillance is appropriate for the care setting and the size of the organisation. Results of surveillance are reported to staff and to the Trust Board. |

## Summary of Attainment

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 19 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 1 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There is no evidence that clinical quality indicators (eg, incident reports, falls, medicine errors, skin tears, bruises, challenging behaviours, and infection and restraint reports) are fully analysed and evaluated to identify tends or that there is a planned approach to minimise or prevent these. | Ensure all quality improvement data is analysed and evaluated to identify trends, and that these results are shared with relevant staff along with strategies to minimise recurrence. | 180 |
| HDS(RMSP)S.2008 | Standard 2.2.3: Safe Restraint Use | Services use restraint safely | PA Moderate |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.3.4 | Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Moderate | Policy has been reviewed and updated and the approval and monitoring forms adjusted but the frequency is not being individually determined according to the type of restraint or the resident risk. | Ensure that the frequency of monitoring is determined by the level of risk associated with the type of restraint in place and any other risk factors identified with the individual resident. | 90 |
| HDS(RMSP)S.2008 | Standard 2.2.4: Evaluation | Services evaluate all episodes of restraint. | PA Moderate |  |  |  |
| HDS(RMSP)S.2008 | Criterion 2.2.4.2 | Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau. | PA Moderate | Policy has been reviewed and updated but the frequency of evaluation and review of approvals is generic across all residents and all types of restraint in use (eg, three monthly). This is evidenced n review of two of eight restraint records and from interview with the charge nurse and two caregivers. | Ensure the time intervals between evaluation and review of each restraint intervention is identified and determined by the risks associated with the type of restraint in use and the needs of the individual resident. | 90 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## Outcome 1.1: Consumer Rights

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There was an area requiring improvement identified in the previous certification audit (1.1.3.5) and this has been addressed. Sexuality and intimacy is clearly documented on the long term care plans developed for all residents assessed as requiring hospital and rest home level care to ensure their individual assessed needs can be met. This is also documented on the multidisciplinary team care plan evaluations completed by the registered nurses for each resident on a six monthly basis. The ARRC requirements are met. |

#### 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:** |
| Policies and procedures identify, and have a common theme, which includes all residents` rights to full and frank information as per the Open Disclosure Policy reviewed. The Open Disclosure Policy clearly defines open disclosure and the organisation’s philosophy, scope and commitment to providing an environment in which staff are able and encouraged to recognise and report any errors or mistakes and are supported through the open disclosure process.   Confidentiality is maintained in a manner consistent with relevant legislation inclusive of the Health Information and Privacy Code 1994 and the organisation’s Confidentiality Policy reviewed.   Interpreter services are available through the Bay of Plenty District Health Board (BOPDHB) if required. Staff represent several nationalities and staff interviewed commented they could translate/interpret if required and appropriate. The ARRC requirements are met. |

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

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

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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 1.1.13: 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 systems in place continue to ensure consumers are advised on entry to the facility of the complaint processes (review of resident entry pack and interview with residents and relatives). As per the requirement in ARC D13.3h, complaints procedures are included in the admission agreement. The complaints register is being maintained. There have been no complaints to the Health and Disability Commissioner since the previous certification audit in 2012. The register contains details of all written and verbal complaints received; seven complaints from July 2012 and five in 2013. Some of these have been received via the Ministry of Health and Bay of Plenty DHB portfolio manager. There is evidence each complaint have been fully investigated, and that the complainants where known, are acknowledged and kept informed during investigations. Each complaint has been resolved and outcomes are reported to the board and staff appropriately (sighted evidence in board reports and interviews with staff). Documents sighted and staff interviewed (eg, registered nurses (RN)s, caregivers, and administrators’) demonstrate that processes are appropriately adhered to. |

##### 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:** |
| The registered nurse manager was not on site or available during this unannounced surveillance audit, and not all elements related to governance could be evidenced on the day of audit (eg, the manager’s personnel records and ongoing education). This is subsequently confirmed by telephone interview and receipt of emailed evidence  which shows the facility continues to be managed by a suitably qualified and experienced manager who has held the position for 20 years.  There have been changes in governance membership, as per the trust deed, since the previous audit and the minutes of board reports for 2013 reviewed, show the manager continues to provide operational and financial reports to the trust board each month.  The service is maintaining its business planning systems which define the scope, direction and goals of the service and monitoring and reporting processes against these. The Quality and Risk Management Plan is aligned to the Business Plan and describes systems for service systems monitoring and review. The organisational chart is current and continues to show the facility manager reporting to the trust board, a rest home charge nurse, and a hospital charge nurse reporting to the manager and a team of caregivers and RNs reporting to the charge nurses. A quality assurance co-ordinator, reception, activities staff, kitchen and laundry/housekeeping and maintenance staff report to the facility manager. The manager’s job description describes the authority, accountability and responsibility.  There are sound financial management systems and procedures and the requirements of the Age Related Residential Care Contract A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5 are met. |

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

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

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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 1.2.1.3 (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 manager was unexpectedly absent on the day of audit and the RN/clinical manager is substituting in the manager’s role. This person has been employed at the facility for more than three years and is suitably experienced and qualified (confirmed by review of personnel and training records and interview). This is the known and accepted protocol for planned or unexpected facility manager’s absences. |

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Quality and risk activities are co-ordinated by a quality support person with input from the RN Manager and delegated staff. Quality and business activities are generally integrated across all aspects of service delivery, although the sighted quality meeting minutes for 2013 do not include discussion about clinical indicators for service delivery (eg, incidents, infections, complaints). These types of quality indicators are reported monthly to the board by the nurse manager (board reports for 2013 sighted) and the RN charge nurse confirmed on interview that these are discussed at RN meetings. A sample of RN meeting minutes shows that incidents are discussed and staff interviews (eg, three caregivers, two RNs, one activities co-ordinator, the quality support administrator, maintenance, and kitchen staff) confirms they are kept informed and have understanding and involvement in quality and risk systems.  Apart from what is reported to the board, there is no in-depth analysis of incident data which identifies and arrests trends. The sampled incident reports show a steady and regular number of medicine errors (eg, found medicines) for the last part of 2013 and there is no evidence of a planned approach to minimise or prevent these (interview with quality support, charge nurse and sample of 2013 meeting minutes from staff, RN and quality committee meetings). This is an area identified for improvement in criterion 1.2.3.6.   Interviews with four residents and two relatives confirm that they are actively consulted through surveys, frequent one-to-one discussions with staff, and at care evaluation meetings. The results of the annual resident/relative surveys conducted March-April 2013 reveals positive and constructive feedback from participants with a 92% satisfaction result. Where there were opportunities for improvement these are documented and changes implemented. Then residents were re-surveyed in September which resulted in a 100% satisfaction.   All policies have been reviewed in July 2013 and staff were informed about policy and process changes (confirmed by staff interview and review of policies).   The internal audit and monitoring programme which measures and monitors the quality of service delivery, adheres to what is described in the annual quality goals, and service policy. There is evidence of timely follow-up on corrective actions where these are identified. Corrective actions are documented on the internal audit forms, complaints forms and the accident/incident event reporting management system. There is evidence that corrective actions are monitored for progress and completion (interview with the quality support person and review of quality documents).  Health and safety policies and procedures are documented and health and safety is discussed at three monthly health and safety committee and other staff and quality meetings. Environmental audits for safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets, which identify hazardous chemicals, are available. There is an accident/incident reporting system. Staff orientation/induction and the education programme includes information on health and safety. Specific risk assessment tools are utilised in service delivery plans to identify and manage clinical risk. Four residents' files sampled demonstrate that clinical risks are identified in the service delivery plans, that informed consent has been obtained and that there is multidisciplinary team input. Any identified hazards are reported and the hazard register is current and kept updated (sighted and interview with two maintenance staff).  The service complies with 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.. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Quality and risk activities are co-ordinated by a quality support person with input from the RN Manager and delegated staff. Quality and business activities are generally integrated across all aspects of service delivery, although the sighted quality meeting minutes for 2013 do not include discussion about clinical indicators for service delivery (eg, incidents, infections, complaints). These types of quality indicators are reported monthly to the board by the nurse manager (board reports for 2013 sighted) and the RN charge nurse confirmed on interview that these are discussed at RN meetings. A sample of RN meeting minutes shows that incidents are discussed and staff interviews (eg, three caregivers, two RNs, one activities co-ordinator, the quality support administrator, maintenance, and kitchen staff) confirms they are kept informed and have understanding and involvement in quality and risk systems. There is no in-depth analysis of incident data which identifies and arrests trends. Incident reports show a steady and regular number of medicine errors (eg, found medicines) for the last part of 2013 and there is no evidence of a planned approach to minimise or prevent these (confirmed interview with quality support, charge nurse and sample of 2013 meeting minutes from staff, RN and quality committee meetings). |
| **Finding:** |
| There is no evidence that clinical quality indicators (eg, incident reports, falls, medicine errors, skin tears, bruises, challenging behaviours, and infection and restraint reports) are fully analysed and evaluated to identify tends or that there is a planned approach to minimise or prevent these. |
| **Corrective Action:** |
| Ensure all quality improvement data is analysed and evaluated to identify trends, and that these results are shared with relevant staff along with strategies to minimise recurrence. |
| **Timeframe (days):** 180 *(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:** |
| The adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms (sample of incident and accident forms from 2013 to January 2014 are reviewed). Events/incidents are discussed at shift handovers and all incident reports are reviewed by the charge nurse and/or the RN manager as appropriate (confirmed by staff interviewed and observation of handover). Numerical totals of all incidents in the rest home and the hospital are reported to the board. These are categorised by type (eg, falls, behaviour, bruises, fracture, skin injury, wandering, and near miss) and compared over a three month period. Each report includes a brief narrative that discusses known trends and some preventative measures. (Note: There is a corrective action required in 1.2.3.6 related to the analysis, evaluation and sharing or quality results with staff). There is sufficient evidence in the incident/accident and complaints records that staff understand and adhere to processes for informing and engaging with consumers and/or their family/whanau about adverse events or complaints.  The service complies with ARC D19.3a.vi.; D19.3b; D19.3c |

##### 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 effective human resources management systems implemented before commencement of employment and on-going staff training to facilitate safe and effective practice. There are effective processes for orientation and checking competency of newly engaged caregivers. There is adequate on-going staff education which is related to the care of older people as per the requirements of ARC 17.6. RNs are peer assessed to ensure they maintain knowledge and competency. On-going staff performance appraisals occur annually as required in ARC 17.7. There is an on-going programme of staff development as required in ARC 17.8.  Five personnel files sampled contain copies of relevant job descriptions. Staff from a range of disciplines interviewed (RNs, caregivers, the cook, maintenance staff, activities co-ordinator) confirm they have and understand their current job description. The nurse manager validates professional qualifications and holds copies of the RN's current practising certificates (sighted as current in two RN files reviewed on site)  Good employment and recruitment processes are followed when employing new staff (eg, a recent recruitment processes for a caregiver has evidence of reference checking, and record of the interview questions asked). Police checks, education qualifications and current membership with professional associations are checked before permanently employing staff (confirmed by interview with the charge nurse and the recently employed caregiver).  New staff are overseen by the RN charge nurses in each wing and are assigned a buddy on each shift. Assessments of competence are conducted by the charge nurse after three months employment and then an annual performance appraisal is conducted by either the nurse manager or charge nurses or RNs, depending on the position. There is a planned, documented two yearly programme of staff development and in-service education. Most care staff have completed the ACE training series (one and two) and many are completing the dementia series. An EN is employed to plan and co-ordinate staff education in collaboration with the charge nurses and the nurse manager. This staff member is an ACE moderator and oversees all staff involved in the ACE self-directed education programme. In-service and external courses and the self-directed ACE training provides all care staff at least eight hours of training annually. Five staff files sampled show care staff (from all shifts) have attended at least eight hours as required in the ARC 17.8.   Attendance at each training session is recorded and individual staff member’s educational achievements are documented in their individual personnel records. |

##### 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 staff policy which determines stall levels/skill mix/staff and resident ratios, hours of work, staff allocation in each area, skills and mix, what to do when workload related to resident acuity increases, and recommended hours per resident per week.  Staff numbers were reviewed four months ago following a drop in resident numbers. There is a reduction of one staff member in the rest home and the hospital wings on morning and afternoon shifts. Staff allocations are as follows: Rest Home wing: There are two caregivers (one from 7am to 3pm and another from 7am to 1.30pm) and a RN does three to four duties a week from 7am to 3pm. There are other RNs on site 24 hours a day seven days a week. Afternoon shift there are three caregivers (one from 3pm to 11pm, one from 3pm to 7pm and another from 4pm to 9pm. There is a senior (special duties) caregiver from 11pm to 7am each night.  Hospital wing: There are four caregivers (two from 7am to 1.30pm and two from 7am to 3pm) the charge nurse Monday to Friday and a senior caregiver (special duties - eg, overseas registered and progressing NZ Nursing Council approval and registration). There is an additional caregiver in the east wing who works from 7am to 12.30pm and then again from 5pm to 8pm who assists in the hospital wing from 11am. Afternoon shift there are four caregivers (two from 3-11pm, two from 4-8pm) and a RN from 3pm to 11pm. There is one caregiver and a RN from 11pm to 7am each night.  The nurse manager works Monday to Friday. There is always another RN on call 24 hours and day 7 days a week. There are two activities co-ordinators, one works 35 hours per week and the other 12 hours per week. There are five cooks employed to cover morning and evening food services, there is a dedicated cook and kitchen staff seven days a week. There are dedicated cleaning and laundry staff seven days a week and two maintenance staff. There is a new quality assurance person since the previous audit who works 24 hours a week, and an EN who oversees infection control, internal audits, ACE and staff education. There is a dedicated administration staff member.  RN and care staff interviews reveal that workloads are still manageable with the reduced number of staff on morning and afternoon shifts but the work demands can alter quickly when residents needs change ( eg, deterioration in health, or need for more supervision). The nurse manager confirmed that resident acuity, behaviour and dependency needs are reviewed daily using the staff allocation formulas described in SNZ HB 8163:2005 Indicators for Safe Aged-care and Dementia -care for Consumers. Residents did not express concern about staffing numbers or staff response times. |

##### 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.)* |

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Service delivery is overseen by an experienced registered nurse manager and two charge nurse managers, one for the hospital and one for the rest home level care residents. There is registered nurse cover twenty four hours a day. Either of the two charge nurses are competent to manage the facility in the absence of the manager. The annual practising certificates are reviewed annually and a system has been developed and implemented to ensure this is completed annually for all registered nurses, enrolled nurses and health practitioners contracted to this service. There are ten registered nurses and three enrolled nurses, four medical practitioners who visit regularly every Wednesday, two physiotherapists one from Whakatane Hospital (BOPDHB) and one who practises locally. There is also a contracted pharmacist and a podiatrist who provide services to the residents. All APCs are able to be verified and are clearly documented when verified along with the next expiry date. Details are recorded accurately by the hospital charge nurse who is responsible for this process.  Each stage of service delivery is well managed by the staff. Education is provided to staff at all levels in the form of in-service education, staff meetings and one on one during orientation and when working together as a team which is promoted to ensure continuity of care is not compromised. Trained staff are registered in the professional development recertification programme (PDRP) for BOPDHB. Staff interviewed eight of eight commented that this team approach to service delivery does occur. A staff member from East Wing also helps during the day with the hospital level residents to ensure all individual cares are completed to meet the needs of the residents.  The four of four resident records reviewed (two rest home and two hospital) are well documented and each entry is signed and dated with a signature and the designation of the staff member involved. Short term care plans are developed on admission and after three weeks the long term care plans are developed and implemented to guide staff. The needs assessment performed prior to admission for each resident by the co-ordination service for BOPDHB is taken into consideration when developing the care plans. The previous corrective action request has been addressed related to timely GP assessment following admission and this is observed in the four resident records sighted. Recognised assessment tools are used by the registered nurses, such as Norton Scale, continence assessments, nutritional status assessments, mini mental health, behavioural management charts and others. Evaluation occur six monthly or more often if needed and input from the multidisciplinary team, the resident and family is sought. Handover is provided and this was sighted between the morning and afternoon staff. The registered nurse interview reports that information concerning service delivery is provided at this handover and anytime there is a change the staff are advised. Continuity of care is promoted and the staff rosters are available and reviewed. The GP practice was contacted but none of the four GPs were available for a phone interview. There is no GP cover after hours. The residents two of two and family interviews report they receive care that adequately meets their needs and expectations. The ARRC requirements are met.  Tracer Methodology: Rest Home XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Methodology: Hospital  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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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 1.3.6: 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:** FA |
| **Evidence:** |
| In all four of four resident files reviewed (two hospital and two rest home level) there is evidence of the interventions relating to the residents` assessed needs and desired outcomes. The hospital charge nurse and one senior duties employee (a registered nurse awaiting New Zealand Nursing Council registration) interviewed clearly comprehend and provided an explanation on how to achieve if possible the resident`s individually set goals within timeframes provided. Observations on the day of the audit indicate residents receiving care that is consistent with residents` needs. The service has adequate resources and equipment required to ensure assessments can be made accurately and that services can be provided safely and set goals effectively met, for example wound care management. Appropriate dressings and products are available. Four residents and two family interviews report that the service meets the needs of the resident. The one senior duties staff member and one caregiver interviewed report the care plans are accurate, up to date and do reflect the individual resident`s assessed needs. The ARRC requirements are met. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities co-ordinator was absent on the day of the audit but the assistant is available for interview and evidenced a clear understanding of the programme. The activities assistant interviewed explained how information was sought for each resident during the assessment process. The process includes obtaining information from the resident or family, inclusive of choices of activities they enjoy, risk factors with health status, social information, specific health concerns, physical/functional state, interests, hobbies, church affiliations, cultural affiliations and/or other relevant information, and especially their past life history. This information is the basis for developing the residents` activities plan to maintain their individual strengths and interests. The activities plans are reviewed six monthly usually at the same time as the multidisciplinary review meetings, or more often if required, and are signed and dated by the activities co-ordinator.  The activities plan is displayed weekly. The plan developed and implemented for the week of 27 January 2014 to 3 February 2014 was sighted. General activities inclusive of music, craft activities, singing, exercising to music (also observed), Tai Chi, church services, birthdays and special days are celebrated. Van outings are popular every Friday and activities, such as the ‘men`s shed`, is specific only for men to participate in and is held on a Wednesday. A church service is held weekly and residents can attend on a voluntary basis. The attendance records sighted are well maintained. The activities plan is varied in content, meaningful and motivating and special interests of the residents are maintained. Residents were observed to be enjoying activities throughout the day. One on one activities are provided to the hospital level residents who cannot attend the activities sessions held in the main lounge/activities room. The ARRC requirements are met. |

##### Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

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

#### Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plan reviews and assessments, medical and specialist consultations and admission discharge summaries are clearly documented in four of four residents’ records reviewed. Documentation reflects the evaluations of the long term care plans for all residents six monthly, and more often if required. Interventions are changed to ensure the needs and goals set can be effectively met.  If a resident is not responding to the service interventions being delivered, or their health status changes, then this is discussed with their general practitioner. None of the visiting GPs were able to be interviewed by phone to validate their involvement. Short term care plans are sighted for wound care, infections, changes in mobility, falls, changes in food and fluid intake with the food service manger’s input, and skin care. These processes are clearly documented on the short term plans utilised. Information is also documented on the medical, nursing assessment records and the individual resident`s progress records. The multidisciplinary meetings involve the family, the resident, the hospital and/or the rest home charge nurses, registered nurses, caregivers, the activities co-ordinator/assistant, the GP and any other health professionals involved in the care of the resident. Two family members interviewed report they are contacted if there is any changes or if the progress is different from expected, or for any information to be provided or communicated to the family/whanau. In the front of each resident’s record is a copy of all communication to each family which is recorded on the record contact sheet provided. The multidisciplinary team meetings are another forum to discuss any changes or significant changes in progress if needed with the resident, the family or resident representatives. The ARRC requirements are met. |

##### 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 1.3.12: 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:** FA |
| **Evidence:** |
| The medicines management policy is available and is reflective of current safe practice guidelines. The policy identifies the staff who administer medicines must be competent. Five staff files reviewed evidence that only one of the staff administers medicines and the respective staff member has completed a medication competency to undertake this role. There are ten registered nurses, three enrolled nurses and one ‘special duty’ staff member who are able to administer medications. The Webster blister pack system is utilised. Procedures comply with legislative requirements.  The contracted pharmacy also audits the medications onsite and medication delivered is checked into the system and the stock medication on hand is checked regularly so as to not ‘over order’. The entries are made in red pen with the pharmacist and the registered nurse signing and dating the entries accordingly. Staff interviewed can ring the contracted pharmacist anytime with any queries. The controlled drugs are stored appropriately. The lunchtime medication round was observed and performed safely. The registered nurse wears an apron to identify that the medications are currently being administered. There are no residents that self-medicate medicines. A policy is available if required to guide staff. The medication room is small but functional. The registered nurse retains the keys to this room at all times.  Eight resident medication records are available after being randomly sampled. The records evidence three monthly reviews of the medication for each resident is performed by the general practitioner and recorded on the resident`s individual medication record. The medication records have photo identification on the front record sheet and on the signing medication record. Staff signatures can be verified and the list is kept in the nurses` station. Also signatures are recorded on the medication records.  There is an area of improvement identified in quality management (1.2.3) in relation to medication (medication found on the floor) not being reported to management every month by staff.   The ARRC requirements are met. |

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

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

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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 1.3.12.3 (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:** |
| All food prepared in the kitchen is produced in accordance with the menus and recipes provided and under hygienic conditions to provide food of a high standard and to be free from potential safety hazards (chemical, physical and or microbiological). Policies and procedures are available on all aspects of food service. The food manger interviewed explained that all food preparation is undertaken within appropriate areas and using appropriate staff and equipment. The menu plans for summer months are provided five weekly and the winter menus are four weekly. The menus have been prepared by a Canterbury dietitian and dated May 2012. A menu audit was performed 6 April 2013 and reported by management to staff on 28 May 2013. The guidelines are available and have been reviewed July 2013 and are next to being reviewed June 2015. Multidisciplinary team reviews are completed three monthly. All residents’ families complete the nutritional profiles on admission.  All fridges/freezers are monitored daily. The food services manager interviewed has worked at this facility for six years. Part of the role is to interact with the residents daily. A new initiative is the food safety handbook being developed by the food service manager and is currently in draft form. When the handbook is finalised this will be available for all staff as part of the orientation programme and ongoing education. The food manger is provided with the monthly weights of residents by the registered nurses and the food service manager records and graphs the weight for each individual resident. Advice is provided when residents have significant gains or weight losses for one reason or another. Weight monitoring is discussed at the multidisciplinary team meetings. Only one staff member has yet to complete national papers 167 and 168 on food safety. Certificates are available for staff who have completed the educational requirements and certificates are displayed.  Special foods/diets can be ordered and the cook caters for all residents to meet their individual needs. One resident is being ‘peg fed’ and is catered for appropriately. Special days, events and functions are also catered for as required. Food prepared is very suitable for the elderly. Cultural needs are considered.   Staff is adequate in the kitchen for this facility consisting on the morning shift of one supervisor/cook, three staff, including one assistant cook, one kitchen-hand and one morning tea staff member. In the afternoon there are two cooks and one kitchen-hand. Food and dry stocks for emergencies is currently stored seven days ahead at all times and a storeroom is available which is dry and appropriate. All meals are served from the kitchen daily. There is a risk management plan and a hazard register dated July 2013. Cleaning schedules for tasks to do on a daily basis are reviewed and additional high cleaning is organised with maintenance staff or contracted providers as per the schedule reviewed. The ARRC requirements are met. |

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

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

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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 1.4.2: 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:** |
| The physical environment and facilities promote safety and privacy for residents. There is an ongoing building and equipment maintenance programme and an annual electrical calibration plan all of which are being maintained (confirmed by site inspection and interview with two maintenance staff). The Building Warrant of Fitness certificate expires 12 November 2014.  There are improvements to the building which have positive impacts for residents. There is a new external deck/platform from the main dining room with good shade cloth, safe and suitable furniture and shelter from the wind. The desk from the hospital wing has clear PVC curtains installed on three sides to provide wind shelter and a full perimeter fence with electronic gate entry is in place since the previous certification audit in 2012. The ARC contract requirements are met. |

##### 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 previous corrective action (criterion 1.4.3.4) related to the peeling paint surfaces in the hospital sluice room has been rectified by repainting the interior walls. This matter is now resolved. |

#### 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:** |
| The previous corrective action related to regular reliable checking of emergency trolley equipment is now resolved. Inspection of contents and monitoring of emergency trolleys in both the rest home and the hospital wings provides evidence that all itemised equipment is in place and within its expiry period for sterilization. |

##### 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.)* |

# 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 eight residents with restraint interventions on the day of audit; these are bed rails and fall out chairs. There are no enablers in use. The two previous corrective actions related to the frequency of monitoring and evaluation criteria 2.2.3.3 and 2.2.4.2 are yet to be fully resolved. |

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

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

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

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

Services use restraint safely

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous corrective action related to the frequency of monitoring in criterion 2.2.3.3 has not been fully implemented. Policy has been reviewed and updated and the approval and monitoring forms adjusted but the frequency is not being individually determined according to the type of restraint or the resident risk. Monitoring is reliably occurring every two hours as seen in review of two of eight restraint records and interview with the charge nurse and a two caregivers. |

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous corrective action related to the frequency of monitoring in criterion 2.2.3.3 has not been fully implemented. Policy has been reviewed and updated and the approval and monitoring forms adjusted but the frequency is not being individually determined according to the type of restraint or the resident risk. Monitoring is reliably occurring every two hours as sighted in review of two of eight restraint records and interview with the charge nurse and a two caregivers. |
| **Finding:** |
| Policy has been reviewed and updated and the approval and monitoring forms adjusted but the frequency is not being individually determined according to the type of restraint or the resident risk. |
| **Corrective Action:** |
| Ensure that the frequency of monitoring is determined by the level of risk associated with the type of restraint in place and any other risk factors identified with the individual resident. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Services evaluate all episodes of restraint.

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous corrective action related to the timeframes between evaluation and review of ongoing restraints in criterion 2.2.4.2 has not been fully implemented. Policy has been reviewed and updated but the frequency of evaluation and review of approvals is generic across all residents and all types of restraint in use (eg, three monthly). This is evidenced in review of two of eight restraint records and from interview with the charge nurse and two caregivers. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous corrective action related to the timeframes between evaluation and review of ongoing restraints in criterion 2.2.4.2 has not been fully implemented. Policy has been reviewed and updated but the frequency of evaluation and review of approvals is generic across all residents and all types of restraint in use (eg, three monthly). This is evidenced n review of two of eight restraint records and from interview with the charge nurse and two caregivers. |
| **Finding:** |
| Policy has been reviewed and updated but the frequency of evaluation and review of approvals is generic across all residents and all types of restraint in use (eg, three monthly). This is evidenced in review of two of eight restraint records and from interview with the charge nurse and two caregivers. |
| **Corrective Action:** |
| Ensure the time intervals between evaluation and review of each restraint intervention is identified and determined by the risks associated with the type of restraint in use and the needs of the individual resident. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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##### 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:** |
| Surveillance is managed by the infection control co-ordinator and the infection control team. The infection control co-ordinator is an enrolled nurse who is well supported by a team of registered nurses including the manager, the two charge nurses for the rest home and hospital and two registered nurses. Hand hygiene is promoted at all times. Surveillance monitoring occurs which includes data on lower respiratory chest infections, skin infections, incidences of MRSA and ESBL and/or VRE, influenza, urinary tract infections, eye infections and any gastro-enteritis outbreaks. Expert advice can be sought from (BOPDHB) infection control team if required or from the Pathlab diagnostic microbiologist if and when required. The data is collated and reported to the team. The Infection control co-ordinator also documents a narrative summary which is included with the report. The manager reports the outcomes to the Trust Board. The infection control reports were sighted in the Kawerau Social Services Trust manager`s reports dated 27 June 2013, 31 October 2013 and 28 November 2013. The meetings are held the last Tuesday of the month for 2014. The surveillance system is appropriate for the size and nature of this aged care facility. The ARRC requirements are met. |
| **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.)* |